GPSpeak

Registrar training concerns

Tresillian opens

Adverse Childhood Experience

Issue focus: Understanding anxiety

Quarterly magazine of Northern Rivers General Practice Network

Summer 2015-16

GPSpeak

Quarterly Magazine of the Northern Rivers General Practice Network

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Contents

Editorial 3

NRGPN Chairman's Report 2015 3

Local concern over Canberra's GP training 5

System's 'racism' still affects Aboriginal renal patients 7

North Coast health chief signs off 9

Understanding anxiety 11

Primary care spending a good investment for older Australians 15

Let's talk about integrated health services 17

Upgraded Casino ED opens for business 20

Order in the House 21

Teaching medical students through role modelling 23

How private lives affect public health 25

The Practice of Mindful Eating 29

Turkey is still a tourist treat 31

Aussie 'medical' movies are all the rage 33

Book Review 34

Front cover: Hot-air ballooning in Cappadocia, Turkey. Further reading for the top 5 activities in Turkey on page 31.

- Angela Bettess

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Editorial

The Australian Financial Review (19 November 2015) reported comments made by two former Treasury Secretaries about the state of Australia's public service. Recent redundancies and increased outsourcing have left the Department short of senior management expertise and there has been a general loss of corporate knowledge. Dr Parkinson noted that junior staff are missing out being properly mentored, "Becoming an effective policy advisor requires learning by doing under the guidance of experienced hands - an apprenticeship if you will".

The slash and burn approach of the Abbott years has similarly affected primary health care and training. The philosophy of the Liberal / National coalition is to reduce the Public Service and the direct provision of services by government. Fostering a competitive market is their preferred mechanism for delivering health and social services.

Thus the awarding of the contract for GP training to a single provider for the whole of NSW came as quite a surprise. It is hard to see this arrangement fostering a market that competes on quality as well as cost, as noted by the article on page five.

The 2015 Beach report into general practice activity (reviewed p15) highlights the central place of general practice in co-ordinating patient care for improved outcomes. It recommended further investment in this area. The importance of this is also recognised by NSW Health with its $130 million dollar investments in Integrated Care programs around the state, by the RACGP (see Dr Edwin Kruys, Queensland Faculty Chair, Let's talk about integrated health services p17) and most controversially by Dr Norman Swan in his recent 4 Corner's program, Wasted.

The Robinson MBS review and the Hambleton Chronic Care review have yet to be delivered. They may however define the financing arrangements necessary to underpin a new integrated health system.

To move to this brave new world will require courage and leadership from the profession. However, it will also require a genuine commitment from the Federal government to finance quality primary care.

It would be unwise for any reforms under a Turnbull government to slash primary care funding and burn the profession's trust in the process.

NRGPN Chairman's Report 2015

"We were caught in the middle of a railroad track, I looked round and I knew there was no turning back" *- AC/DC, Thunderstruck*

The principal activities of our Network are the publication of GPSpeak magazine, the issuing of its associated electronic newsletters and regular maintenance of the website. The Network's media strategy allows it to fulfil its constitutional objectives of fostering communication between Members and to promulgate the views of North Coast general practitioners to other members of the health profession and to the general public.

The Northern Rivers General Practice Network (NRGPN) made a $20,000 loss this year, mostly from the addition of a hard copy version of GPSpeak, published at the start of each season, to the existing online magazine. The paper magazine is sent to all medical practitioners in the Tweed and Richmond valleys and to specialists on the lower Gold Coast. In the future we will also distribute to allied health practitioners and pharmacists in our area.

The magazine has increased

cont P4

NRGPN Report (cont)

in size with this edition being 36 pages. Advertising revenue has been growing steadily and we are projecting running costs will become less of a drain on the Network's finances in the coming year.

GPSpeak remains the only independent media outlet covering health issues on the North Coast. This is only made possible through the support of our sponsors and advertisers. I would particularly like to thank our accountants and major sponsor, Thomas Noble and Russell, for their help and advice over the last 12 months. I am also very appreciative of the support we have received from Sullivan Nicolaides and Partners, not only in their role as sponsors, but also in delivering the magazine to North Coast medical practitioners.

As members would know, the NCML was the successful tenderer for the new Primary Health Network in our area. The North Coast PHN (NCPHN) commenced operations on 1 July 2015. Our contract with the NCML for administrative support ended on 1 April 2015 but the NCPHN has generously continued to support the Network through the provision of Leanne Tully as our part time administrative officer. Leanne has had the unenviable task of corralling busy GPs into meetings and teleconferences and has done so with grace and patience. We truly appreciate her dedication.

This month the Network welcomes Luissa Everingham to the newly created position of NRGPN financial administrator. Her skills will put the Network and GPSpeak on a sound financial footing and allow the Board to direct its attention to new services and activities for Members and for the improvement of health care in our area.

Financial issues dominate the public and health discourse at this time and will come into increasing focus over the next 10 months in the lead up the 2016-17 Budget, and later, the Federal election. Reduced funding for PHNs, GP training and GP rebates may be justified as efficiency measures but this approach may well prove counterproductive.

The Network and GPSpeak will continue to advocate in the community and liaise with and lobby our politicians, Federal and State, for a strong primary health care sector as the best way to achieve a sustainable, yet equitable, health system.

- Dr David Guest; Chairman 2015

Japan EduVenture

7 - 10 February 2016

The AMSN's Feb 2016 Eduventure will be held at the Tangram Madarao Tokyu Resort in the ski resort rich area of Nagano, on Honshu the main Island of Japan.
The CPD activity will run from Sunday the 7th of February to Wednesday the 10th of February over 4 afternoons allowing you to spend some quality time with your family and friends skiing the slopes so you can combine your professional development with some much deserved rest and relaxation.

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Local concern over Canberra's GP training

The federal government's decision to appoint a Sydney-based organization, GP Synergy, to manage all GP registrar training in NSW, including the Northern Rivers, has disappointed a number of Northern Rivers GPs, although they realise the decision cannot be reversed.

Many of these concerned GPs believe the tender was awarded on the basis of outright cost rather than the ratio of service quality to running costs - in short, that it was little more than a 'Canberra cost cutting exercise', as one put it.

Among the concerned doctors is long-time local Chris Mitchell who says his practice will not take further registrars after 1 January 2016 when the new contract comes into operation.

The decision to change the GP training provider arrangements was announced in the federal budget 2014-15. Details released this April included a national map that consolidated the number of training regions from 19 to 11. In NSW, regions were reduced from six to three. The Northern Rivers, indeed, the whole North Coast, fits into 'North Eastern NSW'.

In October, Sydney-based GP Synergy was announced as the successful tenderer to deliver GP training in each of the three new training regions in NSW & ACT – North Eastern NSW, Lower Eastern NSW and Western NSW.

Of the 1,580 training places for next year, 520 are in NSW. As one of the nine new national organisations, GP Synergy will be in charge of almost one third of Australia's GP Training.

"I believe the Government's focus is now on saving money rather than delivering excellence"

- Dr Chris Mitchell

North Eastern NSW will be the biggest training region with an intake of 265 registrars, about 17 per cent of the nation's GP Registrars.

Consequently, there is a real risk that NSW and particularly the North Coast region will have a much lower ratio of GP Training support staff and Medical Educators per head than anywhere else in Australia.

North Coast GP Training (NCGPT), which has managed registrar placements for the past 13 years, also tendered as part of a consortium with two other regional training providers but was unsuccessful.

The new contract starts from 1 January 2016, with pre-existing arrangements likely to be carried over on a novated basis until June 2016.

Dr Mitchell, a board member of Northern Rivers GP Network, publisher of GP Speak, is one of the doctors who feels that cost factors alone lie behind the tender decision.

He said the reason for choosing GP Synergy over the consortium that included NCGPT had little to do with quality, as NCGPT has a proven track record and has regularly won excellence awards.

"At this stage there is no detailed understanding of what has been agreed to under the tender, just that the total dollars are considerably reduced," Dr Mitchell said.

'We don't yet know what will be delivered on line, what will be delivered face to face, or what current training elements will or will not be provided in the future."

What is clear is that all 39 staff of NCGPT will be made redundant by year's end, with GP Synergy "going to market" to appoint future staff to its local office, likely to be in Ballina or Lismore.

In his latest - and almost

cont P6

GP training - changes (cont)

last - newsletter, NCGPT CEO John Langill wrote, "As you can imagine, it has been a bitter disappointment for all of the staff here at NCGPT who have given so much of their time, energy and passion over many years into creating an outstanding training program for our registrars, supervisors and training practices.

"We were looking forward to helping create a new training organisation that would reflect the values that NCGPT have embedded in our program and our approach to attracting and training outstanding GPs for our region's communities. Sadly, it doesn't look like we will get that opportunity."

Dr Mitchell holds concerns about GP Synergy's governance structure, doubting it is "fit for its new purpose, which is training for all of NSW... While NCGPTs members were local GP Registrars and Supervisors, GP Synergy's members are corporate, rather than individuals, their members including a number of Sydney Divisions, Networks of General Practice and Primary Health Networks," he said.

Dr Mitchell added that medical educators across Australia regard the NCGPT training team, led by Drs Christine Ahern along with Associates Directors of Training, Genevieve Yates and Peter Silberberg, and Senior Medical Educator, Hilton Koppe, as highly successful.

"NCGPT has had some remarkable achievement since its inception. It delivered high quality training and attracted excellent registrars to the area.

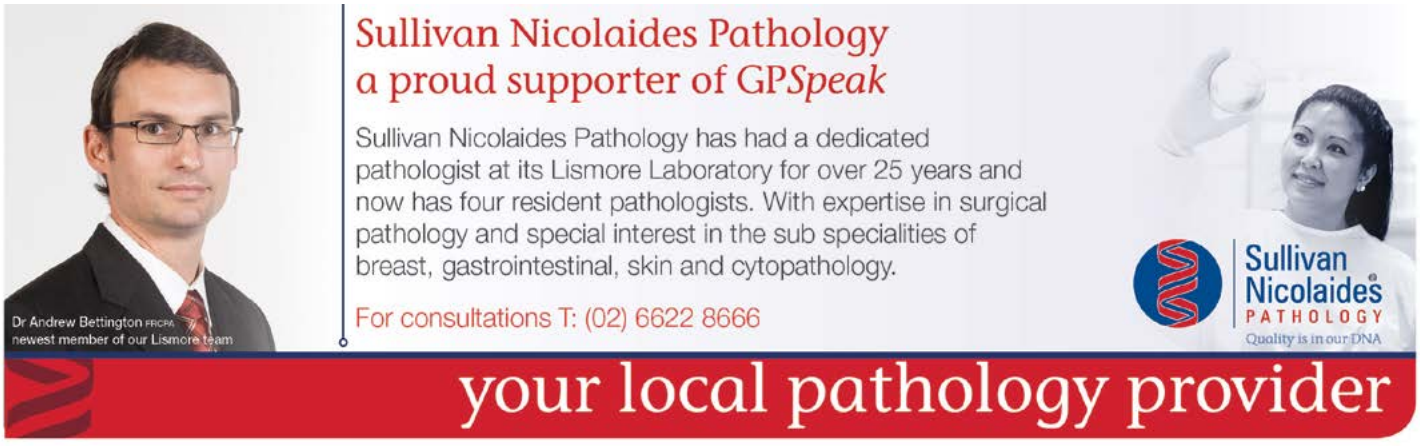
"It had very high rural retention rates for new Fellows. It broke the cycle of short term Sydney rotations and won many awards for excellence for both staff and registrars. NCGPT delivered a truly regional and responsive training program.

"We have seen first hand what excellent regionally focused GP training looks and feels like, NCGPT has set a very high bar for GP Synergy to reach for.

"With the Medical Benefits Schedule (MBS) review seemingly focussed on reducing GP rebates, and the MBS freeze slowly turning up the pressures, we all face challenges maintaining the viability of our practices. Attracting excellent graduates to a career in General Practice may well get harder and harder."

Saying he has been passionate about General Practice and GP education for many years, taking his first registrar in 1994, he feels there are "deep challenges ahead for our profession. I believe without a significant change in Government funding and priorities we may well have seen the best days of GP training."

GP Synergy has developed a set of **FAQs** for registrars, supervisors and stakeholders to assist them during the transition process. These will be added to as the organisation participates in stakeholder forums and additional questions come to light.



System's 'racism' still affects Aboriginal renal patients

Residual trauma from 'Stolen Generation' experiences, cultural insensitivity in parts of the health care system, and memories of discrimination against family members* - broadly linked as 'institutional racism' - continue to impact on the effectiveness of renal care for rural Aboriginal people.

This is a key finding in research for a PhD thesis undertaken through thre University of Sydney by Liz Rix who held lengthy discussions with Aboriginal renal patients in the Northern Rivers region.

Ms Rix, a non-Indigenous person, presented a paper on her research at the October conference of the American Indigenous Research Association in Pablo, Montana USA.

The paper, "Can a white Aussie woman 'get it'? Using an Indigenist paradigm to inform culturally sensitive mainstream renal services for Aboriginal peoples in rural Australia", focused on her role working as a renal nurse and a researcher in an Indigenous setting.

Her research was assisted greatly by a number of local Aboriginal people who helped her gain the confidence and cooperation of renal patients. They included Elders Patsy Nagus, who has since passed away, Russell Kapeen, and Charles Moran.

She also drew on the experiences of a range of health professionals involved in the care of Indigenous patients with renal disease, which Australian Aboriginal people experience at a rate eight times higher than non-Aboriginal Australians.

Ms Rix believes similar views would be held by many Indigenous renal patients across Australia, despite the unique cultural characteristics of each Aboriginal community.

No previous studies in rural Australia have explored the experience of Aboriginal patients with haemodialysis or renal services delivery, and of those providing their care.

Ms Rix found "minimal racism at the individual level, with both participant groups demonstrating the motivation and goodwill for improved relationships and better understanding between them."

However, institutional racism continues to impact on effective renal service delivery, especially in-centre haemodialysis, she found.

Among the findings in her thesis, which has now been accepted, was that 'Family' is a key motivator for persevering with haemodialysis, a demanding process that lasts up to six hours and must usually be undertaken three times a week if done in-centre.

University Centre for Rural

Liz Rix with the painting 'The journey of Aboriginal people in regional & rural NSW on Haemodialysis' by the late Patsy Nagus who assisted with her doctoral research.

Health North Coast director Professor Lesley Barclay AO, one of her supervisors, said, "Liz Rix's research is a significant contribution to the body of knowledge about one of the major diseases affecting Aboriginal people, not just on the North Coast but Australia-wide.

"She has done brilliant research in a field that is clinically and culturally complex, and the future beneficiaries will include renal patients and the health professionals who help care for them."

* A participant recounted being born in the mortuary at Casino Hospital in the 1950s because her mother was not allowed to birth in the Maternity Unit with the white mothers: this impacted throughout her life and negatively influenced her ability to trust mainstream services.

Harald Puhalla
GENERAL SURGEON

Assoc Prof Harald Puhalla, MD FRACS is an experienced general surgeon with a subspecialist interest in bariatric, hepato-pancreatic-biliary and upper gastrointestinal surgery. He was trained at the University Hospital of Vienna under the guidance of international leaders of surgery and has a particular interest in the latest surgical techniques, including minimally invasive treatment concepts.

With a PhD background and an interest in teaching and science he became the Professor of surgery for Griffith School of Medicine at GCUH, where he holds a public appointment.

Harald is known for his compassionate and holistic care to achieve the best possible results for his patients. His bariatric patients especially benefit from his close cooperation with highly experienced bariatric dietitians/exercise physiologist and psychologists.

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North Coast health chief signs off

After 15 years running the region's health service - under various names, and varying footprints - Northern NSW Local Health District CE ***Chris Crawford*** *(pictured right) will step down at the end of 2015. Over a suitably healthy lunch (Japanese) with GP Speak editor Robin Osborne, he reflected on his time in this highly challenging role.*

To be clear from the start, Chris Crawford is not going anywhere, except in early January 2016 when he takes his younger son on a trip through the mostly southern states of the USA. He did a similar trip with his elder son, focusing on the eastern states.

For permanent living, however, Chris loves the Northern Rivers, "A place where many people come to retire, but we [his wife Catherine Cusack is a Liberal Party Member of the NSW Upper House] came here while we were working, and we still are, and we're still here."

But the US looms large in their lives, with Chris and Catherine spending time experiencing what many outsiders regard as the unfathomable US presidential election process. During his January trip, the first of the primaries will be taking place - in the southern states.

Chris loves Canada, too, again its politics, and is currently reading *Full Circle - Death and Resurrection in Canadian Conservative Politics.*

That's not to say he only reads about conservatives - he's looking forward to knowing more about Canada's new PM, Justin Trudeau - nor just political histories. He is currently embroiled in the fourth book in the Millennium series, The Girl in the Spider's Web, the one not penned by Stieg Larsson.

It is reassuring to hear that he has relaxation time, because Chris Crawford PSM (the Public Service Medal, awarded for outstanding government service) is legendary for long working hours and dedication to his job.

He has been employed in the public health sector for 28 years, some six of them as head of St George Hospital and community health, and many people find it hard to imagine his letting go.

Life after the NNSWLHD won't be dull, he assures us, saying he will leave with fond memories and the satisfaction of a job he feels was well done.

Asked about highlights, he nominates the extensive redevelopment of Lismore Base Hospital, still under way, moving rehab to Ballina Hospital, changing Campbell Hospital, Coraki to a HealthOne model, and the current building of a new Byron Central Hospital, worth $88M.

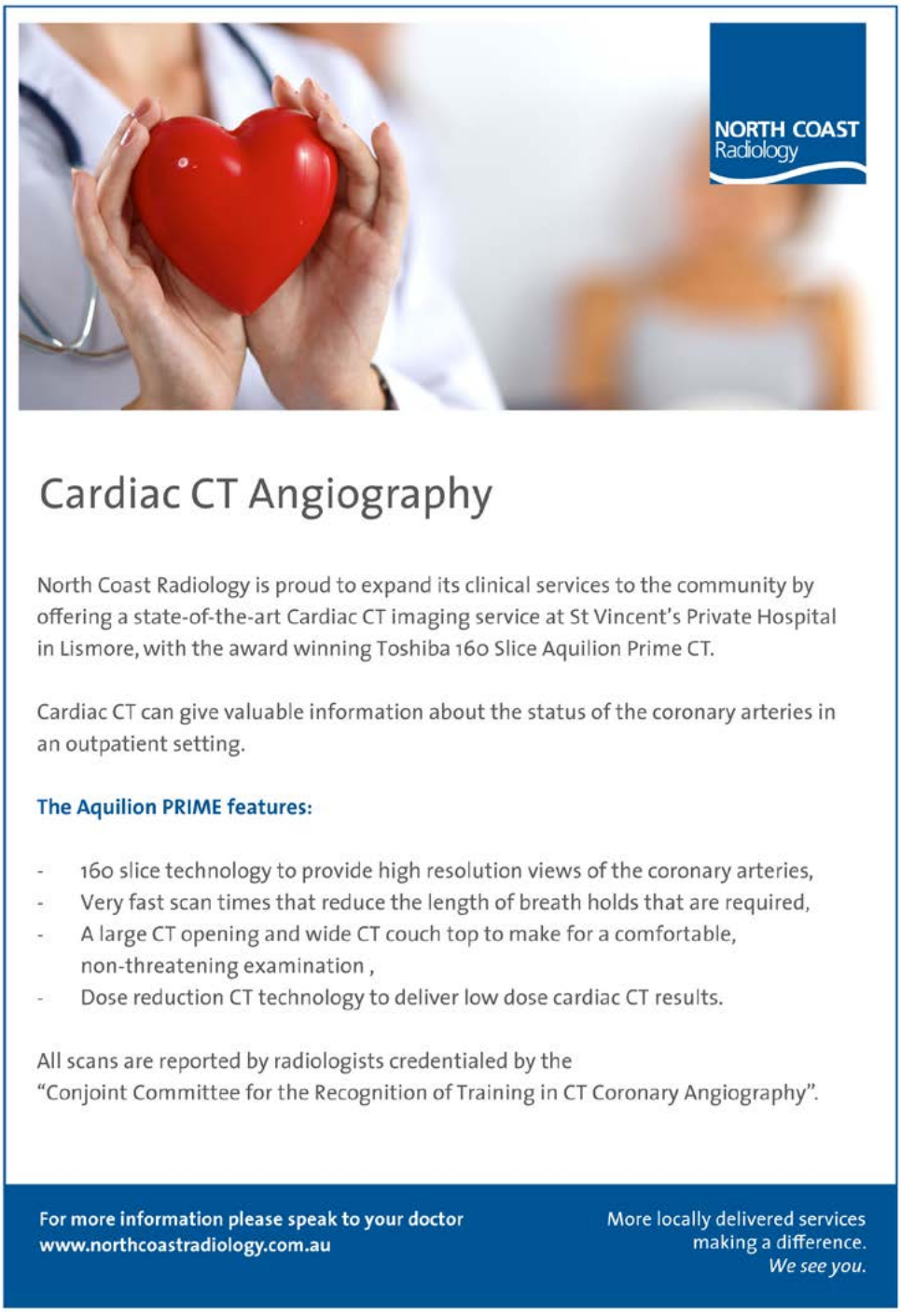
"I believe we have taken the region's health system closer to a metro model, with significant enhancements to technology - MRI, CTs, cardiac cath labs - many more specialists, both medical and nursing, and superb facilities in areas such as mental health.

"The population growth up here has created the demand and the expectation for such services, and a great many of these challenges have been met."

Disappointments have been few, he said, although he wishes that the new Byron hospital could have been developed quicker. He recalls that in his first month here, 15 years ago, he met with community reps from the north and south of the Shire, to discuss a new facility but it has taken this long to get it built.

"As usual, there were some financial constraints, but the delay was largely because the community couldn't agree on the location, and discord of this kind causes concerns for

cont P10



Health CE (cont)

government."

He feels that where the system - and not just in northern NSW - may be failing the community is in the area of health literacy.

"We need to better explain the need to take good care of themselves, and how to do so, both in terms of lifestyle behaviours and in seeking care early when problems arise.

"It's vital to communicate the benefits of healthy living and timely diagnosis and treatment, and to do so in an audience appropriate way.

"Generally speaking, the middle classes are managing well, but there are significant special category groups who are not, for example drug users, which is a high percentage up here, mental health clients, and many Indigenous people.

"GPs are ideally placed to assist with this, and to join the public health sector in the integrated care journey."

What might come next?

Not surprisingly, politics rears its head again, and government. Chris is eyeing a PhD on the intersection between the two, and is working on the best angle. He also intends to set up an online blog. For those seeking an insider view on how western governance work, it should make for fascinating reading.

Understanding anxiety

It seems many Australians are not seeing a doctor about their anxiety because they don't think the condition is serious enough, or don't believe they can be helped. One public figure holding this view is former Labor leader-turned media bomb thrower Mark Latham. In his role as a panellist on Channel 9's The Verdict, he criticised doctors for 'over prescribing' drugs for depression because they are 'misdiagnosing' the condition, which is only anxiety, and that's 'just being a bit worried'. As ***Dr Rosalind Foy*** *explains, anxiety is not only widespread and of significant concern but it can be managed effectively.*

While anxiety is a common term, there is little agreement about how best to define it, although fair definitions include worry about uncertain outcomes, or psychic tension due to a fear of a real or imagined danger.

Most of us understand it because most of us know the feeling of being anxious, and it is not, in itself, a bad thing. It can stimulate us to step outside our comfort zone to achieve things of which we were not aware we were capable. It can signal to us to use our resources to minimize a threat to our wellbeing. But when it controls us, paralyses us, makes us avoid living and reduces our self-confidence, our attitude towards anxiety needs to change.

The two main predictors of an anxiety disorder are a family history of the problem and early adverse experiences.

Studies show that around 14 per cent of the population experience anxiety as a disorder, a statistic that sits within the broader finding (2007 National Survey of Mental Health and Wellbeing) that 45.5 percent of Australians between 16 and 85 years have a lifetime prevalence of a mental health disorder, with one-fifth having had an episode in the last 12 months.

More than 6 per cent (one million people) had experienced a mood disorder, with 5.1 percent having a substance misuse disorder. Anxiety disorders are highly comorbid with other anxiety problems such as depression and substance use disorders.

Dr Rosalind Foy

women, one-in-three of whom had visited their general practitioner, compared to one-in-six men.

Anxious individuals fear the loss of control, the unknown, negative evaluation by others and illness/death. Along with feeling helpless and needy they also have the fantasy that they should be omnipotent and omniscient, able to

2007 National Survey of Mental Health and Wellbeing	
Anxiety disorder	Prevalence %
Panic disorder	2.6
Agoraphobia	2.8
Social phobia	4.7
Generalised anxiety disorder	2.7
Obsessive compulsive disorder	1.9
Posttraumatic stress disorder	6.4

Only 34.9 per cent of those with any disorder are known to seek help, most of them

cont P12

Anxiety - the amygdala (cont)

control their environment and lives in order to feel the "safety" of being all-knowing and self-sufficient.

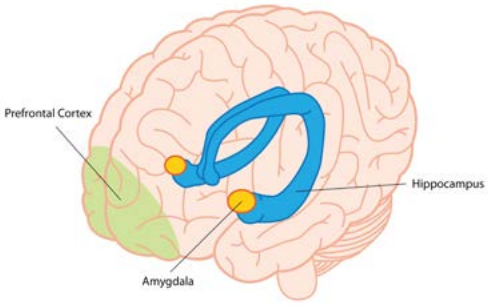
Neuroscience and Biological Models

The amygdala, a part of the limbic system, has been studied the most in relation to the fear response. Through its link with the hippocampus, the amygdala is where emotions and memory are combined. It is part of the mammalian subcortical brain that quickly registers strong emotional stimuli such as fear and aggression as well as pleasurable feelings such as sexual drive and sociability.

This is so that we can make a fast decision whether the person coming towards us is friend or foe. The amygdala sends out efferent fibres that mediate autonomic, endocrine and behavioural responses to these emotions. Hyperactivation of the amygdala is seen in many types of anxiety. In PTSD there is both hyper- and hypo- activation.

The ventral hyperactive region is related to acquired fear responses (eg flashbacks, exaggerated startle response) and the dorsal hypoactive region is involved in the autonomic blunting, emotional numbing and dissociation of PTSD.

One of the amygdala's myriad connections is with the medial prefrontal cortex (MFPC) that regulates the fear provoking stimuli coming from below.



Specific and social phobias are due to an exaggerated fear response, whilst PTSD and panic disorder have the fear component as well as inadequate emotional regulation by the hypoactive MFPC. The fear response is sensitized by early or more recent trauma.

Like other mammals, humans have a panic system which is associated with separation distress. Infants signal their need for parental care by distress vocalizations. Panic attacks stem from sudden arousal of the separation-distress system, whether it is an actual or symbolic separation. They can be modulated particularly by opioids but also by oxytocin and prolactin. There is a deficit of opioids in panic disorder. This could partly explain the anxiety disorders' comorbidity with substance misuse.

Hormonal and autonomic responses to threat are mediated via the hypothalamic-pituitary-adrenal (HPA) axis. The hypothalamus receives afferent fibres from the amygdala, which then activates the sympathetic autonomic nervous system (causing increased heart rate, sweating, pupillary dilation) and the parasympathetic system (causing urinary and gastrointestinal disturbances).

The fight-or-flight or acute stress response leads to increased secretion of cortisol which increases glucose metabolism in the short term but in the long term leads to a decreased immune response, higher risk of CVAs and myocardial infarcts, poor memory retrieval and impaired learning and depression.

The stress response also leads to an increased production of noradrenaline from the amygdala and related limbic system structures. It is thought that there is chronic central hypersecretion of noradrenaline in anxiety, with consequent hyporesponsiveness of central post-synaptic receptors. Serotonin has both anxiogenic and anxiolytic effects. The GABA (the major inhibitory neurotransmitter) – benzodiazepine receptor molecule is disrupted in anxiety disorders.

Psychological Models of Panic Disorder

The cognitive-behavioural model views panic as a learned fearfulness of bodily sensations. The initial panic attack develops from misfiring

cont P13

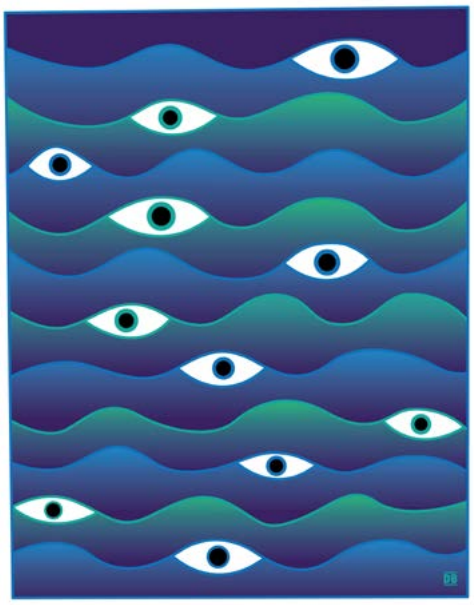
Anxiety - psychological models (cont)

by Dr Rosalind Foy

of the fear system often triggered by stressful life events in psychologically vulnerable individuals. This panic attack becomes the traumatic event and causes further heightened arousal, misinterpretation of physical sensations and fear. A fear of fear develops.

Although the initial panic attack is thought to be precipitated by a past experience, intrapsychic conflict and unconscious causes of fear are not considered central to cognitive-behavioural therapy (CBT).

One psychodynamic model posits that the panic prone individual has an inherent fear of the unfamiliar, making them more dependent on their parents for a sense of safety. Children with insecure attachments will experience any separation with significant distress and will have an ongoing fear of a recurrence of separation. This fearful dependency can also arise from developmental traumas such as over-controlling parents or parents who threaten abandonment. The child then sees the parents as unreliable and rejecting and this can elicit angry feelings in the child. This in turn leads to feelings of inadequacy and further feelings of anger at being dependent upon unreliable parents. Thus anger, often unconscious, disrupts attachments and can be associated with fear.



A Proposed Integrated Model of Panic Disorder

Panic prone individuals may be genetically predisposed to the development of an oversensitized fear network and separation-distress system from early life. Traumatic early developmental memories can also cause the exaggerated fear response. Trauma memories are encoded in the amygdala which is also involved in the expression of anger. Psychological distress due to intrapsychic conflicts (e.g. feeling controlled by others yet feeling unable to be assertive because of a concomitant wish to be dependent), fear of separation and negative affects such as anger, activate the sensitized fear system which is inadequately modulated by higher cortical centres such as the MPFC.

Anger may be triggered with fear. This can lead to more fear as the expression of anger may cause the loss of the attachment figure or more intrusion by them. Thus the separation-distress system can be activated by anger as well as fear. An anxious individual will feel that relationships are more easily threatened, that they themselves are more needy and incompetent and that others are more critical and abandoning. This puts attachments at risk and heightens the onset of panic.

Management

Simplistically, medications act from the bottom up, that is, on the amygdala and basal ganglia and psychotherapy works from the top down by augmenting prefrontal cortex processing and emotional regulation. However, psychodynamic psychotherapy also acts at the subcortical unconscious level through the emotional and psychic attachment between therapist and patient.

Overactivity in the core fear system can be reduced by anxiolytics such as benzodiazepines. Antidepressants such as the SSRIs (e.g. fluoxetine), SNRIs (such as duloxetine), NaSSA (e.g. mirtazapine) and tricyclics (e.g. nortriptyline) increase levels of serotonin and noradrenaline in the synaptic space.

CBT works in the here and now through re-educating patients to correct misconceptions, to modify negative mental representations of events

cont P14

Clinical tip - Metformin, CKD with gastroenteritis

Scenario

- Metformin is safe to use in chronic kidney disease (CKD) when the eGFR is greater than 30ml/min.
- Diuretics are often needed for volume control in CKD.
- If your CKD patients are on metformin and a diuretic consider giving them the following advice:

"If your vomiting, diarrhoea or fever last longer than 24 hours do not take your metformin and diuretics and contact your GP for possible same day review."

(If the patient has concomitant heart failure you may just withhold metformin and continue the diuretic.)

Blood pressure and diabetes control are the cornerstones of management of diabetic kidney disease. As patients age they are at increased risk of acute kidney injury. To reduce the risk of metformin associated lactic acidosis and renal damage you should educate your patients to withhold metformin and diuretics and seek medical review in the event of a dehydrating illness.

Medications may be restarted when the acute illness has resolved.

by Graeme Turner, Nurse Practitioner Chronic Kidney Disease, Lismore Base Hospital

Anxiety (cont)

and to change their self-regulation of thoughts, feelings, and behaviours, e.g. sleep hygiene, moderate exercise, healthy diet, a decrease in caffeine and other substances, and challenge negative thinking. Possible causes of fear and interpersonal difficulties as manifested in the therapeutic relationship are not examined.

Although short-term CBT has been used with effect on some anxiety disorders, it requires the patient to continually practise the techniques they are taught. In the treatment of patients who have early implicit memories of trauma, where fear has neither words nor logic, cognitive processes cannot be activated immediately.

Long term psychodynamic therapy allows emotional connectedness between patient and therapist, helps to modify implicit memories by creating a secure environment for open communication, intimacy and trust. The patient learns to sit with their anxiety rather than avoid it and feels held and contained by the therapist.

Repressed unconscious feelings such as anger and fear that the patient has towards significant others from the past and present can be named, owned and worked through. The dyad co-create a meaningful narrative initially through mainly unconscious thought (where 95 per cent of our thinking occurs), affect, intuition, perceptions, play, dreams and myths. The compulsive need for absolutes and certainty diminishes – one becomes more open to seeing and experiencing what is rather than what should be.

Psychological flexibility makes ambiguity more tolerable and calm is achievable in the face of uncertainty as one's sense of agency increases. Imagination and creativity are given space so that one can grow and better realize one's potential. Changes at the subcortical level are slow but profound, emotional rather than intellectual.

Long term therapy has been shown to have more enduring effects than short term work, even after termination of treatment. The patient comes to know themselves better, learns to process and regulate their emotions and undo habitual ways of thinking via the prefrontal cortex, thus making conscious what was previously unconscious.

I know that there is so much more to know, and in the journey to more knowing, we are growing.

Rosalind Foy is a psychiatrist in private practice in Brunswick Heads. Her particular interest is in long-term psychotherapy of anxiety, depression and personality vulnerabilities in adolescence through to older age.

Primary care spending a good investment for older Australians

The latest results of Australia's longest running study of general practice activity has found that older Australians account for the nation's highest use of primary care resources, and the proportion they are using is increasing over time.

However, the money is well spent, lowering overall health care costs by reducing expensive specialist and hospital visits, and contributing to greater longevity.

Noting that in any one year, about 85 per cent of the population makes at least one contact with a GP, The University of Sydney's Bettering the Evaluation and Care of Health (BEACH) analysis focused closely on the highest users of GP services - older Australians.

The analysis of the 2014-15 data compared the amount of GP health resources older people used with this age group's representation in the population.

The USyd team* found that while 65+ year-olds accounted for 14.7 per cent of Australians, they registered 27.8 per cent of all GP interactions, 28.7 per cent of GP clinical face-to-face time, 35.0 per cent of all problems managed, 35.8 per cent of all medications used, 30.8 per cent of all imaging and pathology tests ordered, and 32.2 per cent of all referrals.

In short, around 15 per cent of people used about twice as many health resources as the average Australian.

"We also found that older people had more diagnosed chronic conditions than younger people," the researchers said.

"General practices are in a prime position to act as the coordinators of care..."

"Having multiple diagnosed chronic conditions increases both the complexity of the patient's care and the resulting health resource use. We found that 60 per cent of people aged 65+ in the population had three or more diagnose chronic conditions and one-in-four had five or more.

"One-third of older patients at GP encounters were living with chronic pain...

Older patients were taking more medications (just over five on average) which is known to increase the risk of adverse drug reactions."

On international comparisons, they found that Australia's total health care spending is similar to comparable countries such as the UK, Canada and NZ, and we have one of the world's longest life expectancies.

While Australia spends about half the USA's per capita outlay on health, our life expectancy is four years longer (83 years versus 79 years).

This may well be because primary care is the core of Australia's system, with GPs acting as what the team called the "gatekeepers" to more expensive care.

"We found nearly all older patients (98.6%) have a regular general practice... This provides GPs in that clinic with a shared patient health record which helps continuity of care. It also lowers the risk of test duplication and fragmentation of services."

They said that if general practice were not at the core of our health care system, "it's likely the overall cost of health care would be far higher.

It is generally accepted that early diagnosis and management of chronic conditions is part of quality health care.

"The combination of early diagnosis and our ever-increasing life expectancy

cont on P18

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Tweed Day Surgery

Dr Matthew Green is a Corneal Transplant specialist recently returned from an 18 month appointment at Moorfields Eye Hospital in the UK where he received specialised training in corneal, cataract, refractive and glaucoma surgery. Now North Coast residents can take advantage of having a Corneal Transplant specialist located right here in Tweed Heads.

In his new practice, Tweed Eye Doctors at 56 Wharf St,

Dr Green also has an active research interest in the epidemiology of microbial keratitis. For this research he has been awarded a Master's of Science from the University of New Wales and an Australian Research Award from the Australian Government's department of Education. He also researches in the areas of DMEK surgery and Boston Keratoprosthesis, has multiple publications in international peer reviewed journals and presents regularly at international conferences.

International medical aid is a keen interest of Dr Green since visiting Nepal and Burma as a surgeon. He has also lectured on the prevention of trachoma on a remote island in Fiji and contact lens fitting in Nepal.

Dr Green also specialises in;

1. Cataract surgery
2. Pterygium surgery
3. Corneal graft surgery
4. Laser refractive surgery
5. Collagen Cross-Linking for Keratoconus
6. Glaucoma treatment

Dr Green is a Queensland trained Ophthalmologist originally qualified as an Optometrist at Queensland University of Technology and completed his medical degree at University of Queensland.

Dr Green completed his residency at Gold Coast Hospital and registrar training in public hospitals in Brisbane, Gold Coast and Lismore, then he recently completed subspecialty training at the world famous Moorfields Eye Hospital, London.

Advertorial

Let's talk about integrated health services

This article was first published on **Dr Edwin Kruys' blog "Doctor's Bag"** on 30/10/2015.

It has been described as the holy grail of healthcare: the patient at the centre and the care team working seamlessly together, no matter where the team members are located, what tribe they belong to or who their paymaster is.

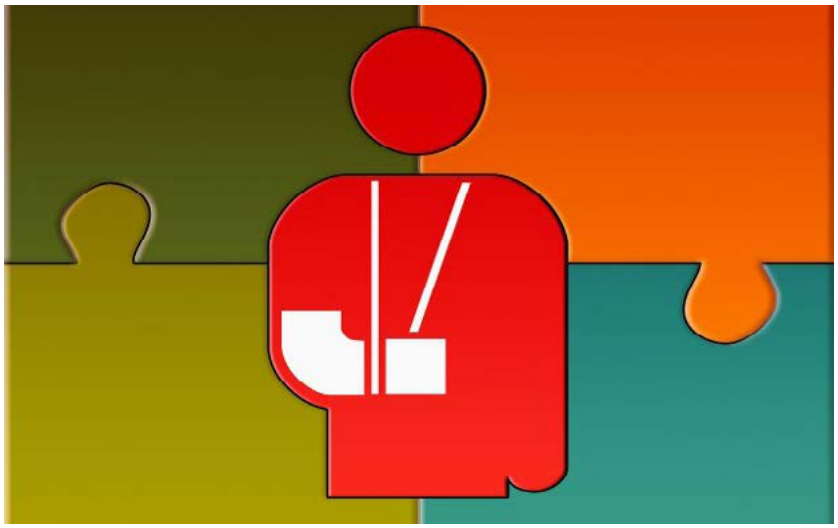
Integration has been talked about for many years. The fact that it's high on the current political agenda means that there's still a lot to wish for. Although we have high quality healthcare services, our patients tell us that their journey through the system is everything but smooth. Most health professionals are painfully aware of the shortcomings in the the system.

What is integration?

So what do we mean when we talk about integration? Co-location of health professionals? Team meetings between doctors, nurses and allied health professionals? Hospital departments talking to each other? Communication between GPs and specialists? Working across sectors? Packaging preventative and curative services? Patient participation? One electronic health record? A shared management and funding system?

Integrating health services means different things to different people. For that reason the WHO proposes the following definition:

"Integrated service delivery is the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."



Integration is a means to an end, not an end in itself. Sharing resources may provide cost savings but, says the WHO, integration is not a cure for inadequate resources. Obviously, integrating services doesn't automatically result in better quality. It's also worthwhile noting that co-locating services does not equal integration.

There is a difference between integration from a consumer point of view, which often implies seamless access to services, and professional integration, which is achieved through mixing skills and better collaboration. These two types of integration don't necessarily go hand in hand.

So it is useful to ask: what problem are we trying to solve? Are we trying to improve the patient journey through the health system? Do we want to support health professionals to deliver better care? Or is the main driver government concerns about costs?

How to achieve it?

One thing is certain: we must fight fragmentation. This is challenging as we are seeing a wave of commercially driven, disruptive services appearing in the healthcare sector. These solutions may be attractive to consumers because they are convenient, but they usually don't contribute to a better or more integrated health system.

cont P18

Let's talk about integrated health services (cont)

Unfortunately the evidence around integration is limited, but the authors of this MJA article are suggesting a way forward. They have looked at international health reform initiatives improving integration between community and acute care delivery, and they found that the following 10 governance elements are essential to support integration:

1. Joint planning. Governance arrangements included formal agreements such as memoranda of understanding
2. Integrated information communication technologies
3. Effective change management, requiring a shared vision
4. Shared clinical priorities, including the use of multidisciplinary clinician networks, a team-based approach and pathways across the continuum to optimise care
5. Aligning incentives to support the clinical integration strategy, includes pooling multiple funding streams and creating equitable incentive structures
6. Providing care across organisations for a geographical population, required a form of enrolment, maximised patient accessibility and minimised duplication
7. Use of data as a measurement tool across the continuum for quality improvement and redesign. This requires agreement to share relevant data
8. Professional development supporting joint working, allowed alignment of differing cultures and agreement on clinical guidelines
9. An identified need for consumer/patient engagement, achieved by encouraging community participation at multiple governance levels
10. The need for adequate resources to support innovation to allow adaptation of evidence into care delivery.

Major paradigm shift

The first thing we need is a shared vision. A major paradigm shift towards more integration requires motivated and engaged stakeholders and champions, a shared sense of purpose and a culture of trust. This should be established before embarking on a new journey. We must avoid making the same mistakes that have caused so much havoc in projects like the PCEHR.

It will be a challenge to get health professionals to focus more on coordination instead of daily care delivery. An essential step here is to increase capacity. The last thing we need is an overloaded primary care sector such as in the UK. The RACGP is suggesting an overhaul of primary care funding to faciliate integration and coordination. Similar changes will be required to free up hospital doctors to e.g. discuss patient cases with primary care providers.

The big question is: who will take the lead? It is likely that a lot of work will happen at a local level and primary health networks could play a crucial role here. A shared agenda, clear goals and genuine stakeholder involvement are keys to success.

Follow on Twitter: @EdwinKruys

BEACH

cont from P16

means we have more chronic conditions being managed for longer, consuming a growing amount of health resources for their management.

"This is the price Australia pays for good health, but we would argue this price is very reasonable."

The study concluded that, "General practices are in a prime position to act as the coordinators of care and help lower the chance of fragmented care. If our government wants to make our health care system sustainable, it should invest in primary care to improve the integration of, and communication between, these different parts of the health system."

*Helena Britt, Graeme C Miller, Joan Henderson, Clare Bayram, Christopher Harrison, Lisa Valenti, Carmen Wong, Julie Gordon, Allan J Pollack, Ying Pan, Janice Charles

Quality is having information at your fingertips

Sullivan Nicolaides Pathology have clearly been busy innovating and redefining the way in which clinicians and pathologists interact as they bring to market three exciting technology based products.

SonicEdu is the digital version of the Sonic Pathology Handbook — a practical, in-depth reference that has been developed to assist Australian doctors in their day-to-day clinical practice.

Written by 65 Sonic Healthcare pathologists, the handbook provides information on more than 900 pathology topics, and reflects a deep, collective knowledge across all areas of pathology, including specific, high-level expertise in a broad-range of subspecialties.

Importantly, the handbook has been written by Australian pathologists for Australian doctors, making it a unique resource within our medical community. The digital versions contain up-to-date information, giving you immediate access to the latest test information and position statements. The digital versions are available on IOS and Android platforms and on desktop PCs through the Sullivan Nicolaides Pathology website.

Sullivan Nicolaides Pathology have also released the much-anticipated pathology results app – Sonic Dx.

Sonic Dx is a feature-rich app that is intuitive and easy to use. It has been developed in close consultation with clinicians and pathologists to provide you with quick access to your patient results, when and where you need them. It also has enhanced functionality that allows you to track specific patients and securely email results directly to a colleague or patient.

Sonic Dx replaces Webster Mobile and Webster desktop will be transitioned to Sonic Dx over the next few months.

Doctors who have an existing Webster account can access Sonic Dx on their mobile device using their Webster ID and password. It is simply a matter of downloading the app from the iTunes Store or Google Play, entering your existing Webster username and password, selecting your pathology practice, and you're ready to go. (If you do not have your username and password, register at Sonic DX or email Webster@snp.com.au

All these products and other innovations can be found on Sullivan Nicolaides' website which includes easy access for doctors and patients to information relevant to them. There are also easy navigation icons for Sonic Genetics, Sonic Dx, Surgical Skin Audit, Pathology Handbook and Collection Centres. Sullivan Nicolaides Pathology have even provided clinicians with a library of education videos from their pathologists.

Sullivan Nicolaides PATHOLOGY

Upgraded Casino ED opens for business

The long-awaited upgrade of the emergency department at Casino and District Memorial Hospital was officially opened on 7 October, with Federal MP for Page Kevin Hogan jubilant about the Federal government's role in funding the extensive refurbishment.

The upgrade had long been advocated by community representatives, and patients and families, and supported by staff having to work within its confined, outdated space and unattractive ambience.

No more - Casino's 24/7 ED now features a new triage area; two new resuscitation bays; a redesigned Ambulance Entry for all weather conditions and to provide safer entry and exit of ambulances; four new treatment

Kevin Hogan MP with Lynne Weir, executive director of NNSWLHD's Richmond/Clarence Health Service Group, in the ED at Casino Hospital.

bays; relocation of the waiting area to be in close proximity to Reception and Triage; piped medical gasses for the Resuscitation Bays; multifunctional Safe Assessment Room; dedicated ED staff room; public toilet in closer proximity to the Waiting Room and in view of the Reception/Triage areas; refurbished Clean Utility Room; and improved security for the entire ED.

"It is great that the Federal Government was able to deliver $3 million to ensure that emergency services could continue to be delivered in Casino," Mr Hogan said.

"Thanks to the grant the Northern NSW Local Health District has been able to build at Casino Hospital. This upgrade is wonderful news for the Casino Hospital ED staff, patients and the wider community."

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Order in the House

I opened the new Emergency Department at Casino Hospital last month.

This major $3 million upgrade is wonderful news for the Casino Hospital ED staff, patients and the wider community.

It was due to a Federal Government grant. The previous government promised this during the last election campaign. Visiting it after the election I could see it was badly needed and lobbied the [then] Health Minister Peter Dutton to also honour the commitment.

The upgrade includes a new triage area, two new resuscitation bays, a redesigned Ambulance entry, four new treatment bays, relocation of the ED waiting area, a multifunctional Safe Assessment Room, a dedicated ED staff room, a refurbished Clean Utility Room and improved security for the entire ED.

The Northern NSW Mental Health Integration Plan was launched last month.

The plan grew out of the Page Health Leadership Forum that I established soon after my election in 2013 to promote greater collaboration between the various local health service providers.

Mental health is a major issue in the Northern Rivers and this plan is all about making the journey to recovery that much easier by putting those with mental health issues in touch with the right service when they need it.

We have some wonderful health workers and great services, however, the system is fragmented and the lack of integration of services can lead to poor outcomes for patients.

The new plan was developed by the North Coast Primary Health Network, Northern NSW Local Health District, Aboriginal Medical Services, Mental Health Forum, Mental Health Interagency Meeting and the Northern NSW GP Clinical Council.

I would like to thank all those involved in developing this roadmap on how existing services can better deliver people help to those in need.

The National Disability Insurance Scheme (NDIS) will start to roll out in the Northern Rivers from 2017/18, following an agreement between the Commonwealth and New South Wales governments.

This is great news for people with disability and their families in our community, and underscores our commitment to deliver the NDIS in full.

I read the article in the last issue of GP Speak about the concerns of our local health professionals about Sydney-based organisation GP Synergy winning the tender to manage GP Registrar Training in the Northern Rivers.

I too have reservations about this. However, I am happy that the state was split into three geographical regions.

That said I will continue to monitor the new training system to ensure it meets all its KPI's and delivers quality services for the Northern Rivers.

The new Turnbull Government's focus is on jobs and economic growth.

It is only through growing the economy that we can afford to pay for the quality health services our community needs and expects.

World-class radiotherapy for breast cancer patients

New, world-class treatment for breast cancer patients at Genesis CancerCare Queensland's centre at John Flynn Private Hospital at Tugun is providing peace of mind and a reduced risk of potential cardiac side effects.

Whilst modern radiotherapy for left sided breast cancer is a well-proven treatment with low side-effects, the new treatment further reduces the risk of radiation injury to the heart.

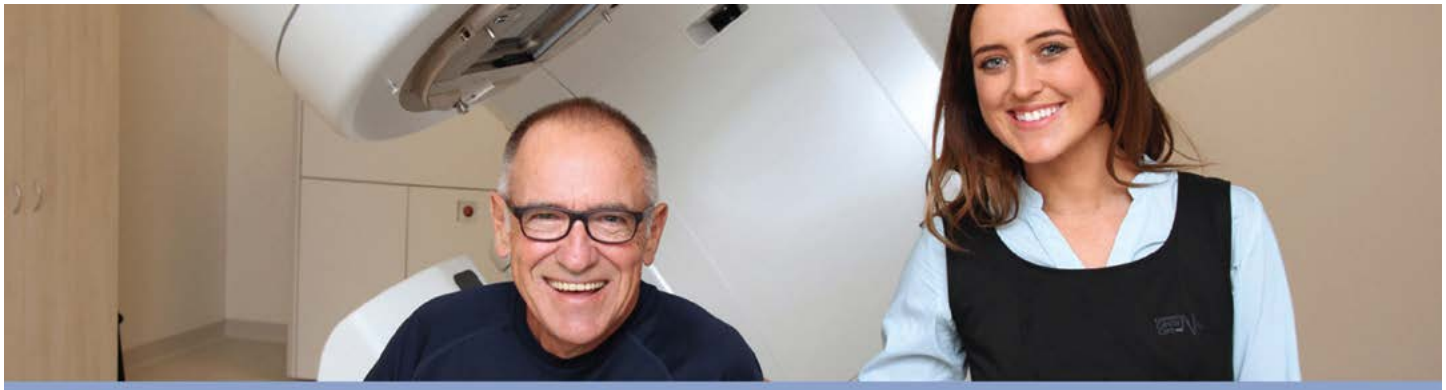
The new Deep Inspiration Breath Hold (DIBH) technique requires patients to hold their breath during their daily radiation treatment. The purpose is to increase the distance between the heart and the left breast. When the natural space between the heart and

the breast is at its greatest, treatment is delivered, reducing the heart's exposure to radiation.

This treatment is a significant clinical advance as well as having important benefits in reducing patient anxiety. The proximity of the heart and coronary vessels in patients with left sided breast cancer can cause concern when radiotherapy is necessary, so the knowledge that radiation risk is reduced can help to lessen some of the traditional treatment stress.

Another first for this treatment is that patients participate directly with their treatment – they wear video goggles that allow them to control their depth of breathing during the treatment by visualising how deep their breath hold is.

For more information about Genesis CancerCare Queensland's radiation therapy services please call (07) 5507 3600 or go to to the website.



No wait, rapid access Palliative Care radiation treatment within 24 hours, on the Gold Coast.

Palliative Care rapid access program available from October 12 at Tugun and Southport Radiotherapy Centres.

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Genesis CancerCare Centres:

Tugun - John Flynn Hospital, Inland Drive
T 07 5598 0366 | F 07 5598 0377

Southport - Premion Place, 39 White Street
T 07 5552 1400 | F 07 5552 1406

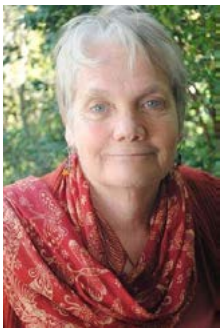
genesiscancercareqld .com.au

Genesis Cancer Care Queensland

GenesisCare

Teaching medical students through role modelling

Jane Barker* reflects on coordinating practicum placements for medical students with local GPs, and the positive feedback they provide.



There are many joys in teaching medical students - their enthusiasm is infectious and is a reminder of all that I love in Medicine. Fortunately for us at UCRH (University Centre for Rural Health, North Coast), more GPs in our area take medical students into their practices than don't.

Many make very significant commitments to teaching, being involved in the longitudinal placements in general practice or taking the more traditional shorter student placements regularly throughout the year. Others do what they are able to do within their own constraints of time and space. Most find this really rewarding.

It is vital that all students, whatever their future aspirations, develop a deep understanding of the pivotal role of general practice in the community, and indeed in all health care. What better place to learn this than our country general practices!

Each week while students are on their general practice rotations, I meet with them and we have time for reflection. They talk about the patients they have seen, but are also acute observers of the GP/patient interaction - if, of course, they have not been left in a corner to nod off...

Students learn through observation and imitation, so we should never underestimate the power of role modelling. In fact, role modelling has been called our most powerful tool in medical education.

Medical student Nick Vitko with GP mentor Dr Andrew Binns.

General practice is a wonderful place for students to really understand the value of good communication, the power of empathetic listening and connecting with patients at a level that allows a deeper understanding of who they are and what their needs are. They come to learn of the importance of continuity of care - not only in note keeping and effective referral and discharge summaries, but of the joy many GPs have in their long-term relationships and friendships with their patients.

Students inevitably comment on this, sometimes in surprise, because they don't see it in the hospital setting, but often in awe. They love the pictures of Juriaan Beek with the generations of babies he has delivered, Juriaan having brought into the world a good half of Casino! They note the breadth of knowledge GPs need to have. They even get excited about seeing an ingrowing toe nail or a case of measles.

More often than not, they find these placements valuable and enjoyable. Sometimes GPs have invited them home or to join them in a run or a cycle. This really makes them feel cared for.

Our students are often overwhelmed by all they need to learn, and it is great for them to see that establishing a work/life balance is a real possibility, even within a busy working life.

We have been hearing a lot about medical student burnout and the development of anxiety or depression. For that

cont P26

Role modelling (cont)

by Dr Jane Barker

reason alone, the role modelling of taking care of ourselves and looking after our own health is really important.

I find it most rewarding when general practice resonates with a student and they feel they have found a future career path, sometimes when they have despaired of ever finding a place they feel they could fit in.

One student reported to me - "I did not like hospital medicine or the way I was being taught. When I went into my general practice it was like a family. The doctors all treated the patients as friends and knew all about them. I learned better in that caring environment."

Of course reports are not always rosy. Sometimes students question when GPs are not following clinical guidelines or evidence base, and we discuss issues of patient centred choices, intuition and how GPs may individualise treatment according to their knowledge of a patient's needs.

Sometimes they have questioned how the GP has related to a patient. Sometimes, though fortunately rarely, they have been unhappy with their relationship with the GP.

Recently in the media much has been discussed about bullying in medicine. It appears that in some areas it is alive and well, but at least it is now being challenged. As with other forms of abuse, it is perhaps generational.

There are those who believe it was the way they learned and was the only way to learn. Others believe it builds resilience, while some are not even aware that the student or junior staff member feels bullied and may be shocked when they realise this is the case.

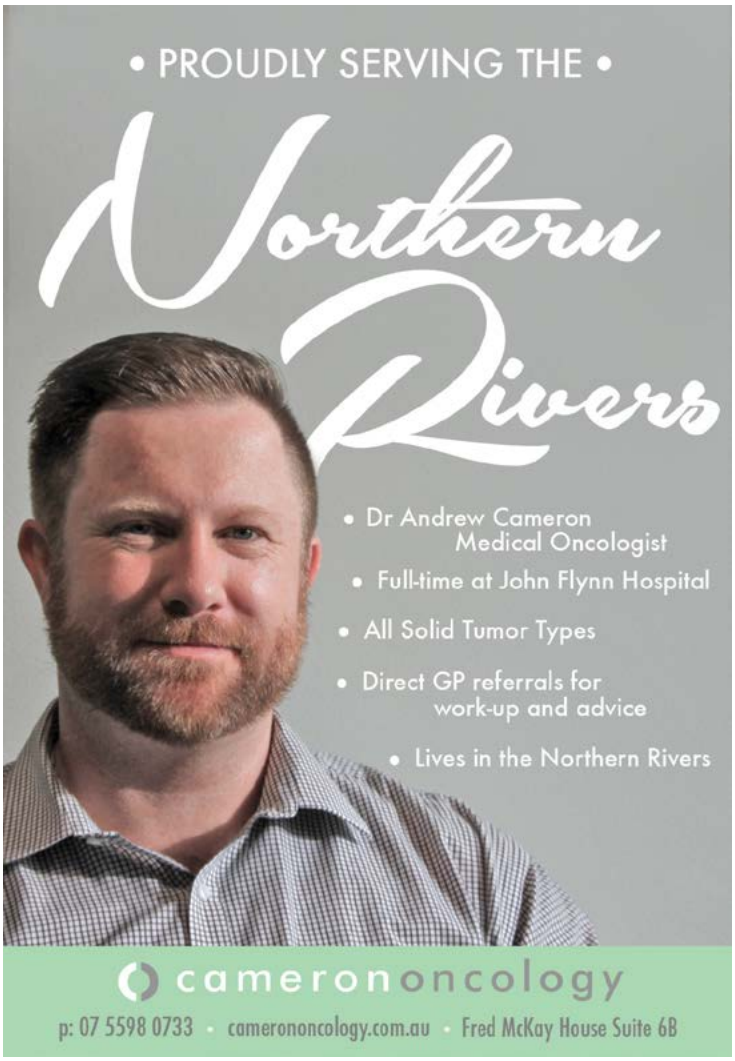
Can bullying really generate competence and confidence? Can we really hope that our future workforce will be caring and compassionate if bullying through intellectual humiliation is what we choose to role model?

Of course GPs may find the students far from perfect – but which of us was at that stage? How best do we instill professionalism? How best do we teach the art as well as the science of medicine? How best do we teach "That to care for a patient we must first care about them?" First and foremost, this has to be demonstrated through our role modelling.

We have a wonderful chance when we welcome medical students into our practices for succession planning and to influence the future of medicine.

"Is this the doctor I want caring for me?", I now ask as I move into middle age. Role modelling is powerful but we should take care what we role model - it could come back to bite us when it is our turn to be the patient!

Jane Barker is a long-serving GP and education coordinator at the University Centre for Rural Health North Coast.



How private lives affect public health

This is the second of a two-part article by Dr Andrew Binns on Adverse Childhood Experience (ACE). The first, "Childhood trauma can trigger later life obesity", appeared in GP Speak issue Spring 2015.

Domestic and family violence has been much in the news of late, occasioned by such dramatic events as the death of Luke Batty at the hands of his father, and a series of killings - at the time of writing, 63 deaths this year. The prevalence of this crime is alarming: one in six Australian women experience violence from a current or former partner.

The widespread community response has included high-level political involvement from state premiers and a commitment by the federal government to a $100M **Women's Safety Package** to improve frontline support and services, leverage innovative technologies to keep women safe, and provide education resources to help change community attitudes to violence and abuse.

Often more hidden but equally concerning are the domestic circumstances - the private lives - under which many of our children are growing up. This significant public health issue was identified in a large US study called **the Adverse Childhood Experience (ACE study)**.

The study followed earlier findings that many morbidly obese Americans had been identified as suffering from physical, emotional or sexual abuse or other adverse trauma in their childhood.

I discussed in an article in the previous (Spring) edition of GPSpeak – 'Childhood trauma can trigger later life obesity'. However, as was found with further research, it is not just morbid obesity that can result from ACEs.

The ACE study was a ground breaking survey in the US by the Centers for Disease Control and the health care provider Kaiser Permanente published in 2009. The survey which was carried out with over 17,000 predominantly middle class Americans measure 10 ACEs on a scale of either 0 or 1 adding to a possible score of 10. (See chart below).

Some 67 per cent of respondents scored at least 1 on the ACEs, while 12.6 per cent had experienced four or more ACEs. There was a close relationship between ACE scores and health outcomes 50 years later. More importantly, the relationship was strikingly dose-dependent. COPD was 2.5 times higher in those with an ACE score of >4; depression 4 times; heart disease 3 times and suicide 12 times.

Population attributable risk figures (the proportion of a problem in an overall population that can be attributable to specific risk factors) showed that 54 per cent of current depression and 58 per cent of suicide attempts in women

cont P26

Adverse Childhood Experiences (ACEs) and prevalence in the US Kaiser Permanente Study	
Abuse	- Emotional (11%) - Physical (28%) - Sexual (28% women; 16% men)
Household Dysfunction	- Mother treated violently (13%) - Household member alcoholic or drug abuser (27%) - Household member imprisoned (6%) - Household member chronically depressed, suicidal, mentally ill, or in psychiatric hospital (17%) - Not raised by both biological parents (23%)
Neglect	- Physical (10%) - Emotional (15%)

How private lives affect public health (cont)

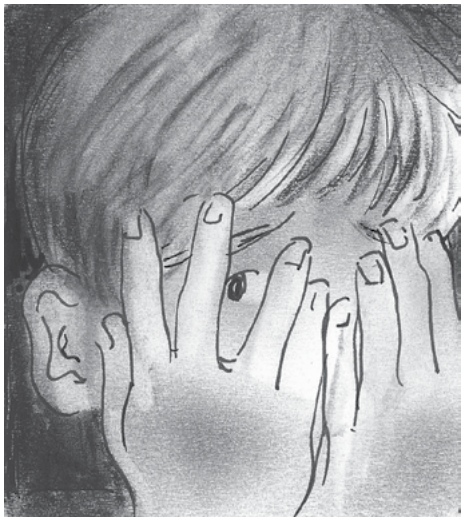
could be ascribed to ACEs. These lead to what has been called 'allostatic load' which can accumulate over the years increasing risk of many diseases.

So what can we do about this significant public health problem in general practice? Becoming a trauma informed practice is a good start as there is evidence that even acknowledging early adverse experiences can assist recovery.

When appropriate, for a GP to just ask about ACEs in a sensitive way often leads to disclosure and this in turn is followed by an appreciation that the problem has been heard and believed, with ongoing respect and support for the patient. This disclosure may not have happened before during a consultation with a health professional. Such an approach opens the way to plan for and arrange appropriate counselling and support.

Whatever therapy is advised, five foundational principles of managing **trauma informed care** should be considered.

1. Safety – ensure physical and emotional safety
2. Trustworthiness – maximise trustworthiness through task clarity, consistency and interpersonal boundaries
3. Choice – maximise choice and control
4. Collaboration – maximise collaboration and sharing of power
5. Empowerment – prioritise empowerment and skill building



The new system will be characterised by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history… open and genuine collaboration between provider and consumer at all phases of the service-delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than a single discrete event, and by a focus on what has happened to the person rather than what is wrong with the person… Without such a shift in the culture of an organization or service system, even the most `evidence-based' treatment approaches may be compromised.

(Ibid, referencing Saakvitne, 2000; Harris & Fallot, 2001)

The fact that people who are long term unemployed often have high ACE scores reveals just how major childhood trauma can affect one in later life. Complex trauma can be overwhelming, not just for an individual but for their families and even their community.

Inter-generational trauma is often seen and when entrenched can undermine the wellbeing, spirit and social cohesion of a whole community. This problem is overrepresented in Indigenous communities.

The Federal Government's move to reduce household violence and the impact on children addresses not only the acute trauma but may result in longer-term public health benefits. The potential flow-on benefits are a reduced prevalence of many chronic diseases, including a broad range of mental health and drug and alcohol problems.

GPs in their primary care role are ideally placed to be at the frontline of listening and understanding the implications of the stories of ACE sufferers, regardless of their age. It is not a matter of 'just get over it' or hoping medications can solve the problem.

Link to further reading

Tresillian's 'life savers' officially welcomed

The latest step in Tresillian's long and proud history was taken in Lismore on 18 November when its new family care centre in Lismore was officially opened. On hand to celebrate this vital support for parents struggling with the demands of a new baby were the organisation's council president, Dr Nick Kowalenko and CEO Robert Mills, representatives of the North Coast Primary Health Network and the Northern NSW Local Health District (the two will provide financial and other support for the next three years), Southern Cross University, Lismore Mayor Jenny Dowell, and Karen Hogan, on behalf of her husband, Federal MP for Page, Kevin Hogan.

Dr Kowalenko, a psychiatrist, said, "It's well documented how effective the Tresillian service is when it comes to supporting new parents. We're pleased that families in the local area will have access to Tresillian's early parenting services without having to travel to Sydney."

Not as happy as Tresillian clients themselves, several of whom attended the opening with their babes-in-arms.

Said Heather Sullivan, holding seven-month-old son Jake, "Tresillian Family Care Centre is quite literally a life-saver, it's been such a great support for us."

Happy Tresillian customers… Nahanni Cox with Cooper (4 months), Heather Sullivan with Jake (7 months), and Jane Hollows with Matilda (6 months).

Speakers at the opening mentioned how parents of all backgrounds can experience difficulties with newborns. Karen Hogan spoke of how a high-level nurse of her acquaintance had struggled with early motherhood.

Dr Kowalenko explained that staff members Tracye Hughes and Clare Forshaw had been seconded to the then-Northern Rivers Division of General Practice to make the family centre happen. They spent a year in Lismore establishing the service: "We are delighted that Tresillian has been able to return to ensure that this service continues well into the future."

Tresillian's operational nurse manager Debbie Stockton said, "It's not unexpected that parents find the lack of sleep and stress of a crying baby impacts on their mood and ability to cope.

"Our nurses are able to identify and support parents who are at risk of, or are experiencing, postnatal depression and anxiety, so the family can receive the help they need as early as possible."

Appropriately, the opening took place during **Perinatal Depression and Anxiety Awareness Week**

Tresillian began life in 1918 as the Royal Society for the Welfare of Mothers and Babies. It now has centres around Sydney and in Albury-Wodonga, and a broadened scope that includes specialised nursing, medical and psychological support, both on site and via the internet and phone.

Tresillian Lismore is at 46 Uralba Street, Lismore, (02) 6622 8705 or Tresillian.lismore@sswahs.nsw.gov.au

DON'T SLIP-UP ON THE SMSF ROAD TO RETIREMENT WEALTH

A SMSF (self-managed superannuation fund) can be a very powerful retirement savings vehicle. It's good for long-term wealth accumulation and asset protection within a tax-effective structure. There is plenty of scope, however, to lose your footing over some of the required compliance tasks.

If mishandled, the potential pitfalls can work to outweigh the benefits of saving for retirement through your SMSF. As a trustee of an SMSF you need to know about them, and as a trustee you should use an adviser like us to help you navigate this administration.

Overshooting the contributions cap

One of the more common mistakes is exceeding the annual concessional contributions cap. Many SMSFs will have their administration tasks completed annually, and in arrears. To avoid overshooting the cap, ongoing updates of contributions received can save headaches, so keep TNR in the loop.

Property pitfalls

Another way to be tripped up is investing in property. If a deposit on an investment property is placed before a SMSF is established, it will not be your SMSF that has bought the real estate but you as an individual. With any investment decision, you should contact TNR to discuss the correct vehicle for you to use otherwise it might be too late or two expensive to correct.

Tangles on pension tax and exceeding limits

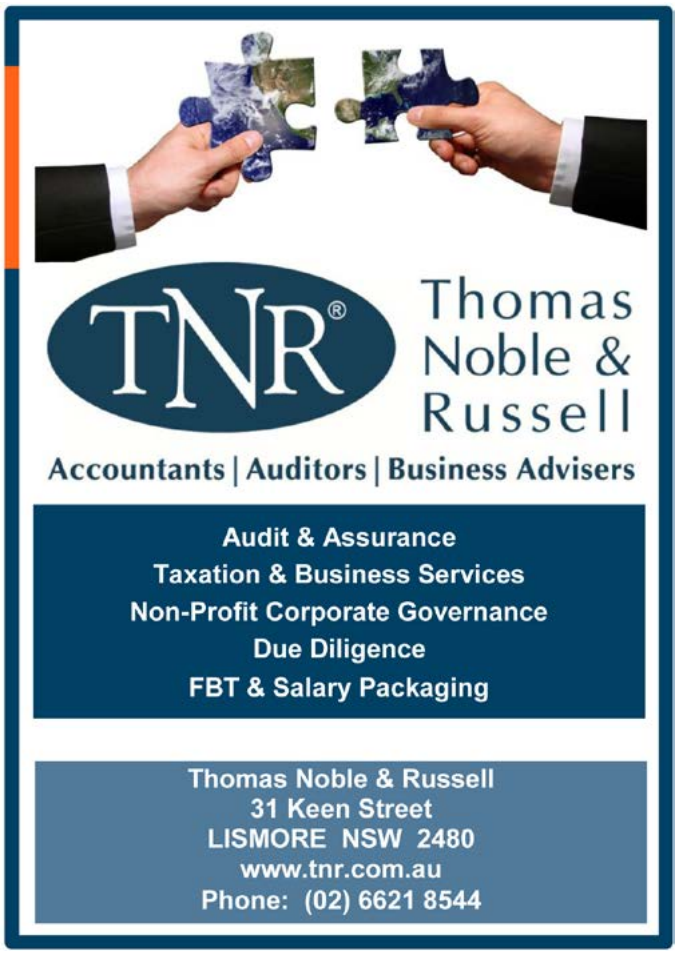
Ordinary income and statutory income that a complying SMSF earns from assets held to provide for superannuation income stream benefits is exempt from income tax. This is referred to as exempt current pension income (ECPI). The Tax Office recommends that funds may need an actuarial certificate to determine the correct amount of exempt income they can claim.

Another mistake with pension payments is not meeting pension limits when the SMSF is in pension mode (minimum and maximum drawdowns) – either not meeting the minimum pension, or exceeding the maximum. We encourage you to ask this office for more details.

Collectible and personal use of assets

The rules for collectible and personal use assets in SMSFs are changing. SMSF trustees who hold collectibles and personal use assets prior to July 1, 2011 will have to adjust to a new set of rules from July 1, 2016 or dispose of these investments prior to June 30, 2016. The purpose of the regulations is to ensure any investment is made for genuine retirement purposes rather any other ancillary purpose.

If you think you have these types of assets in your SMSF or you are unsure, please discuss this with TNR well before July 1, 2016.



The Practice of Mindful Eating

Annie Hewitt is an Accredited Practising Dietitian (APD) and Director of Australian Dietitian. She consults in Lismore, Ballina, Mullumbimby, Murwillumbah and Brisbane on a weekly basis. Annie has experience in chronic disease management and a particular interest in the treatment of food intolerances".

Considering it is such an essential part of our daily lives and health, eating is surprisingly easy to become disconnected from. For many, comfort food cravings - whether triggered by boredom, loneliness or as a reward - are a common experience, with serious health consequences for some. Despite this, there is growing research to suggest that the practice of mindful eating may assist individuals to better manage their cravings and improve their appreciation and relationship with food.

Food cravings

Although food cravings are a common experience for many of us, what makes it different from hunger? Psychological scientist Eva Kemps of Flinders University suggests that the key difference between hunger and cravings is how specific they are. "We don't just want anything, we want salt and pepper chips or chocolate" says Professor Kemps.

While many food cravings come and go, they can pose serious health risks, having been shown to provoke binge-eating episodes that

Annie Hewitt, APD

can lead to eating disorders and obesity.

While research into food cravings is an emerging area of science, studies suggest that cravings for comfort food could be the complex interplay between taste buds, brain, stomach and hormones (a relationship that experts still don't fully understand). Studies also show that certain activities and thinking styles can alter brain chemistry.

Being Mindful

Mindfulness is a form of self-awareness training based on Buddhist meditation. It is defined as paying attention in a particular way, on purpose, in the present moment, and non-judgmentally.

It follows that mindful eating is a practice of mindfulness with a central focus on food and the eating experience. It is defined as paying attention to an eating experience with all senses (seeing, tasting, hearing, smelling, feeling); witnessing, without judgment, the emotional and physical responses that take place before, during and after the experience.

The goal of mindful eating is to appreciate food and explore the eating experience. By using all our senses, mindful eating allows individuals to choose foods that are satisfying and nourishing to the human body.

It also allows individuals to become aware of the positive and nurturing opportunities that arise from food selection and preparation while acknowledging responses to food (likes, dislikes) and learning to be aware of physical hunger and satiety cues to guide decisions on when to begin and stop eating.

The Centre for Mindful Eating has created the following principles intended to guide people who are inter-

cont P30

Mindful Eating (cont)

ested in mindful eating.:

- Mindfulness is deliberately paying attention, non-judgmentally in the present moment
- Mindfulness encompasses both internal processes and the external environment
- Mindfulness is being aware of your thoughts, emotions and physical sensations in the present moment
- With practice, mindfulness cultivates the possibility of freeing yourself of reactive habitual patterns of thinking, feeling and acting
- Mindfulness promotes balance, choices, wisdom and acceptance of what is

The principles of mindfulness has been incorporated in a variety of therapy modalities. Some of the most prevalent treatments include mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT) and acceptance and commitment therapy (ACT).

Results from several studies have shown improvement in chronic disease parameters including blood glucose control, diet adherence, weight loss, and mental well being after mindfulness interventions. An exploratory study involving six weeks of treatment using mindful eating practices resulted in decreased depression, anxiety and binge eating rates among subjects. While available evidence suggests favorable outcomes utilising mindful eating practices, there is a lack of randomized controlled trials to demonstrate the efficacy of mindful eating, therefore calling for further research.

Creating a Mindful Eating Practice

The next time you feel stressed and reach for a chocolate bar, it is important to consciously stop and give yourself the choice. As Dr Rick Kausman, director of The Butterfly Foundation for Eating Disorders said in an interview with the dietitian Stephanie Osfield, "Tell yourself: 'I can eat this if I want to, and I can have it anytime I want, but do I really want it?'" He explains that by "simply posing this question can act as an emotional circuit breaker, making people realise they are in control and can exercise that control to say no to comfort food."

As with learning anything new, practice is essential. There are many triggers, both personal and environmental that can pull us out of awareness in the present moment and back into habitual comfortable routines.

By establishing a daily mindful eating practice we can change this mechanical way of eating. It all starts with making a commitment to set aside a few minutes each day. The Centre for Mindful Eating has useful resources available on their website to assist practitioners and individuals interested in mindful eating.

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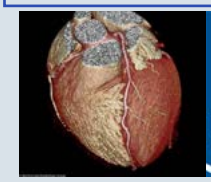
New NCR service



CT coronary angiography is now available from North Coast Radiology at St Vincent's Hospital. It is available as a Medicare rebate when ordered by a specialist for stable coronary ischaemia. Conventional angiography is the gold standard but the new technique has both a high negative and positive predictive value in this scenario.

Turkey is still a tourist treat

Despite a massive suicide bombing in its capital Ankara, an ambiguous role in the war against Daesh (ISIS), and two national elections in five months, Turkey retains its age-old appeal to visitors - justifiably, writes GPSpeak team member ***Angela Bettess.***

There are so many good things to see and do in Turkey, and reducing them to a short-list of five highlights has not been easy. Nevertheless, allow me to share my top five experiences from a recent trip to Turkey lasting three weeks...

1) Hot air ballooning in Cappadocia

Waking up before sunrise was well worth the effort as one hundred hot air balloons floated up into the air above Cappadocia. Serene, wild and unforgettably beautiful, Turkey's central desert landscape was forged by volcanic eruptions resulting in laval formations that have since been shaped by the elements. What remains is a surreal landscape of 'fairy chimneys' – or oddly shaped steeples of rock—that provide an amazing backdrop for the morning flock of multicoloured balloons . Also incredible was the skilful landing of the baskets directly onto the trailers as they came back down to the ground.

Hot-air ballooning in Cappadocia

The Library of Celsus facade, Ephesus

2) Exploring ancient Ephesus

Walking down the main stretch of the ruined city of Ephesus is illuminating. As the once capital of Asia Minor in ancient Roman times, Ephesus has an expansive structural layout with many intricacies. Still preserved are the remains of an amphitheatre once used for concerts, toilets, a gateway leading to the massive façade of the Library of Celsus, as well as a sign in the marble footway leading to a brothel.

3) Bathing in Cleopatra's pool

Along the hill at Pamukkale, shimmering blue pools cascade in tiers. These pools are the result of hot water springs beneath the ground: dissolved calcium precipitates to form the solid white surface that lines the Travertines. It is said that Cleopatra herself enjoyed bathing in the famous Ancient Pool where unusually warm mineral water still flows.

4) Shared stories at Gallipoli

To be where so many ANZACs had died, and also to hear the stories about some of the more personal interactions between the ANZACs and the Turkish soldiers, was deeply moving. The

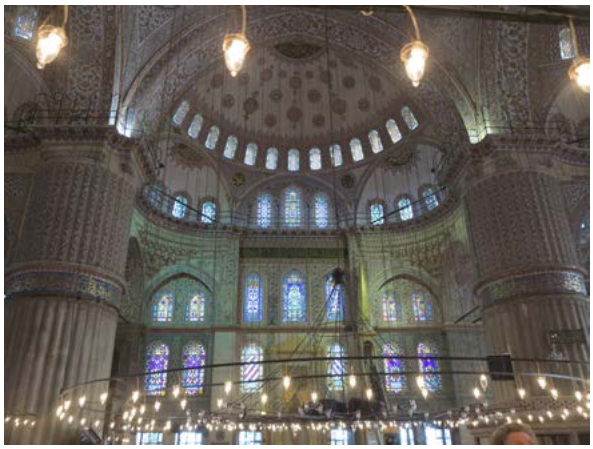
cont P32

Turkey (cont)

experience of this area echoed Ataturk's sentiment from 1934: "There is no difference between the Johnnies and the Mehmets to us where they lie side by side here in this country of ours."

5) Mosques and Markets in Istanbul

Istanbul is a buzzing metropolis with the Bosphorus strait separating East (Asia) from West (Europe). The Hagia Sophia is an important monument to both the Byzantine and Ottoman Empires: originally a church, then a mosque, it now remains a museum of the Turkish Republic. Its dimly lit corridors and gilded domes are exquisite and conjure a wonderful



atmosphere. The Blue Mosque is similarly spectacular, as the only mosque in Istanbul with six minarets and an interior embedded in characteristically blue tiles.

Across the city you will also find bazaars and markets filled with a myriad of shops selling jewellery, intricately painted plates, scarves, leather goods, spices, fresh food and other merchandise. Of particular interest is the famous Spice Market, where delicious produce (such as pomegranate juice) can be tested. This is also where the stairs to the enchanting Rustem Pasha Mosque can be found: although small and with only one minaret, it has a special feel due to its position within the market and the blue tiles found on reaching its door.

Aussie 'medical' movies are all the rage

Diverse medical issues have inspired three of the best Australian films of recent times, Ruben Guthrie (the dangers of alcohol misuse), Last Cab to Darwin (cancer, and euthanasia), and Holding the Man (HIV/AIDS).

Since reviewing the first of these for GP Speak Spring issue I made a point of catching the second on the basis of loving the work of actor Michael Caton (The Castle), who plays a cancer patient/cab driver willing to drive thousands of kilometres for a painless death.

Having spent several recent years in Darwin, I was also interested to see how that city, and the country around it, would be depicted.

The third film had been so widely praised that I simply could not miss it, and I'm glad I didn't.

The story, based on Timothy Conigrave's highly successful 1995 book and a subsequent stage play of the same name, is well known. The author, who died shortly before the book's publication, fell deeply in love with fellow student John Caleo at the Jesuitical Xavier College in Melbourne. The latter was a star Aussie Rules player at school, the game that inspired the clever title of the book: 'holding the man' incurs a penalty on the footy field, while male-male attraction was frowned upon at the school in that era.

I might add that it was far more taboo at my private school in Sydney a decade earlier (the film begins in the late 1970s), and I was surprised at how open minded the Jesuit boys and their teachers seemed to be.

Tim and John's relationship continued into their adult lives, despite occasional straying, the most notable example being the gay bathhouse scenes around Sydney's Darlinghurst. There is some explicit filming, but nothing gratuitous or inappropriate to the storyline.

As was so often the case in the late 1980s, both men contracted HIV, then a death sentence, and after a first half - to use a football term - of exploring adolescent love the film moves into the confronting phase of attempting to manage the dreadful impacts of the disease, which progresses into full blown AIDS.

Central to the story are the ways in which their families cope with learning their beloved sons are homosexual, and later, that they are destined to die.

The cast of high-profile actors (Guy Pearce, Anthony LaPaglia, Geoffrey Rush, et al) in no way outshines the young men around whom the story revolves - Ryan Corr (Conigrave) and Craig Stott (Caleo).

Like the book and play, this is a surefire award-winner.

So too, I believe, is Last Cab to Darwin, an interesting take on the Australian road movie genre (Priscilla, Red Dog, etc) that puts terminal cancer patient Rex, a Broken Hill cab driver, in touch with Darwin-based doctor Nicole Farmer, a Dr Nitschke doppelganger who has the 'exit' equipment to hand, and only awaits the final signoff on the NT legislation.

Based on the true story of cabbie Max Bell, who did this drive-to-death, ultimately thwarted by the federal parliament, the tale is a wonderful piece of celluloid theatre, especially the interactions between Rex and his neighbour/lover Polly (Ningali Lawford-Wolf), an Aboriginal woman of immense tolerance and good humour, and the sparky young Koori hitchhiker Tilly (Mark Coles Smith), a glowing talent.

Like the other film, and indeed Ruben Guthrie, it is a sad, funny, thoughtful and distinctively Australian production, and one that should not be missed.

- Robin Osborne

Book Review

Reviewed by Robin Osborne

The Biology of Desire

by Marc Lewis

Scribe 238pp

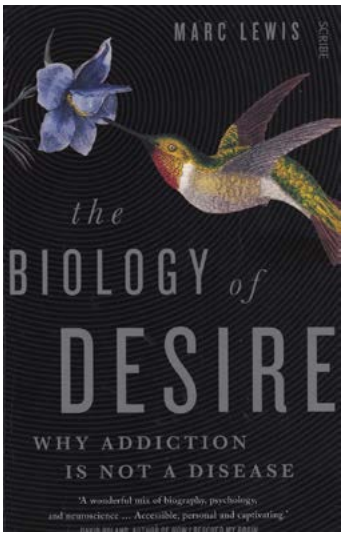
Despite its gorgeous cover, Marc Lewis's latest work (the follow-up to his self-revelatory Memoirs of an Addicted Brain) seems not to match the categorisation of 'Popular Science/ Health', starting as it does with 40 pages of complex physiological description of why, in the words of the sub-title, "Addiction is not a disease".

Yet the book offers vital information for the many with a dependency on substances, illegal or otherwise, or unhealthy behaviours, as well as for family members, friends, and even clinicians - although all may need to re-read some sections to fully comprehend the arguments.

That said, Dr Lewis certainly convinced me of his proposition, and by the time I'd moved through the case histories of people who had moved through drug, alcohol and gambling addictions, eating disorders and more, I was well won over.

A Canadian, this neuroscientist and professor of developmental psychology is now based in the Netherlands. Through most of his twenties he was a drug addict, and since stopping, he has been dedicated to explaining how his brain had "become so addled for such a long time."

To summarise, "After reading thousands of comments and emails from former and recovering addicts and interviewing dozens of them for hours at a time, I'm convinced that calling addiction a disease is not only inaccurate, it's often harmful...



"Many recovering addicts find it better not to see themselves as helpless victims of a disease, and objective accounts of recovery and relapse suggest they might be right... survey research published over the last thirty years indicates that most addicts eventually recover permanently. For them, the disease label may be an unnecessary, even harmful, burden."

The brain is "designed for addiction", he writes, and it would be "useless if it weren't highly changeable, highly sensitive to events in the world."

These events include habits, sometime minor like nail biting, sometimes more serious, such as the use of heroin, methamphetamines, excessive sex, including porn, and so on.

"The brain [which he dubs a "habit-forming machine"] is certainly built to make any action, repeated enough times, into a compulsion. But the emotional heart of addiction - in a word, desire - makes compulsion inevitable, because unslaked desire is the springboard to repetition, and repetition is the key to compulsion."

In comments that relate to other articles in this issue of GP Speak, he writes that "Anxiety and other negative emotions can cultivate new habits," while studies of adverse childhood experiences (ACE) show that a person experiencing early-age abuse or family problems is more likely (500 times) to become an alcoholic, a drug user (4,600 per cent increase in IV drug use), food addict or smoker.

"The traumatised amygdala keeps signalling the likelihood of threat or rejection, even when there is nothing of concern in the environment.... We find something that relieves the gnawing sense of wrongness, we take it, we do it, and then we do it again."

Summarising, Lewis writes that addiction "need be no more than a stage in the development of the self. And that often seems to be exactly what it is... as someone who has known addiction personally, I recognise it as the bounce our lives can take when they've hit the bottom."

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