# GPSpeak

## Lismore comes out

GP training concerns

Student placements

Lifestyle Medicine

Quarterly magazine of Northern Rivers General Practice Network

Autumn 2016

GPSpeak
Quarterly Magazine of the Northern Rivers General Practice Network

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**Front Cover:** *Lismore Mayor Jenny Dowell with members of the Tropical Fruits at the street parade to launch the 2015-16 festival.*

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# Editorial


Sex and drugs and rock and roll ... and death, all essential ingredients of a good Australian mini series, are raised in this issue of GPSpeak.

Each year Lismore plays host to the Tropical Fruits Festival. Our cover and page 12 story feature pictures of the parade taken by talented local photographer Brad Mustow.

However, when the party's over, one can feel a little down. Staff specialist, Emanuel Vlahakis, gives practical advice to general practitioners on dealing with Gender Dysphoria (GD, page 21). Discrimination against transgender patients contributes to high levels of depression and suicidality. Recognising this risk and tapping into local resources to help such patients is a first step.

The acronym, MYEFO, sounds vaguely threatening. It is to the medical profession this year. Robin Osborne (page 18) outlines the changes to health in the Mid-Year Economic and Fiscal Outlook. Sussan Ley's doublespeak and doublethink defense of the changes attests to her being a most valued minister in the Turnbull government.

The Robinson MBS and Hambleton Primary Health Care Reform reviews are unlikely to be released before the Australian Federal Budget on 10 May 2016. Good news is not expected. The freeze on rebates and the slashing of GP training is increasingly frustrating for the profession.

Dr Ruth Tinker (page 4) reflects on the teething problems of the new slimline arrangements. The Northern Rivers General Practice Network (NRGPN) remains dismayed at the loss of the superb program provided by the previous incumbent, North Coast GP Training. Getting GPs to stay in country areas is always difficult but NCGPT did an excellent job of making a career in rural medicine attractive. It will be a difficult task for the new organisation, GP Synergy, to do the same.

On page 13 Andrew Binns continues his look into the issues surrounding voluntary euthanasia. Comedian/Producer Andrew Denton, recalling the death of his father from heart failure 18 years earlier, has recently argued strongly for Assisted Dying in Australia. Denton's detailed review of euthanasia as practised in Europe and North America suggests that such systems can work. However, he notes that there have been 27 failed attempts to introduce laws for assisted dying in Australian States since the Howard government overturned the Northern Territory's "Right of the Terminally Ill Act" in 1997. He lays the failure for the passage of these laws at the feet of Australian doctors.

Dr Binns argues for the status quo and cites Canadian ethicist Margaret Somerville who sees cultural changes in western societies as the main driver for the voluntary euthanasia movement. While self-determination may be seen as laudable, the materialistic approach to life and to death carries increased weight in our secular age. Many are uncomfortable with such a utilitarian approach.

Australian physician, Karen Hitchcock's recent "The right to die or the right to kill?" essay addresses many of the issues raised by Denton. The wish to die will usually not be due to intolerable pain, we are not bad at controlling that, but rather to feelings of despair, worthlessness or of being a burden.

If Denton is right and Australian doctors are failing Palliative Care patients we can address this by at least making it clear about what we can do in "End of Life" care. With the help of our practice nurses, Local Health District and private Palliative Care teams, and local hospices, many patients can end their lives in comfort surrounded by their friends and families.


To support this end, the NRGPN has recently relaunched its Advanced Health Directive suite, MyChoice. The suite comprises a brief explanation of the concepts behind Advanced Health Directives, an assessment tool of the patient's and their carers' needs, and the Directive itself. All of these documents and the accompanying succinct but comprehensive manual can be downloaded from the website http://iccnc.nrgpn.org.au.

The movie, Last Cab to Darwin, reviewed in the last issue of GPSpeak, describes the final weeks of Mt Isa taxi driver Rex's life, dying from stomach cancer. His journey takes him along that long and winding road of feelings of despair, worthlessness and of being a burden. Thankfully, he makes it home safely, which is what we want for all our terminal patients.

The NRGPN welcomes letters to the editor from members, health professionals and the general public. Correspondence should be sent to The Editor editor@nrgpn.org.au.

Members concerned about particular issues may also contact Northern Rivers General Practice Board Directors. The Board membership for 2016 can be found on the NRGPN website under About the NRGPN. The Board meets second monthly on the third Thursday of the month.

The NRGPN also runs a members only list server. Members not on the list server and wishing to join should send an email requesting access to info@nrgpn.org.au.

**- Dr David Guest**

Have your say, we welcome Letters to the Editor at GPSpeak

Send to editor@nrgpn.org.au


# Low rating for new GP training arrangements

**We are now several weeks into the new GP training regime – so how are we doing?**

Firstly in the spirit of full disclosure, I am one who wanted to withdraw services in protest at the centralisation of training providers in NSW. All other existing providers had been told they could only lodge a proposal to manage one of the new regions in NSW. So it came as a shock that one provider had not only been allowed to lodge several proposals, but that that single provider was then granted the entire state.

This means there is no longer any competition between providers, previously touted as an important way of improving quality.

Secondly, it seems not even they believed they would be granted the whole state. They had no idea how they would do it, no plans in place, not even a skeleton structure on which to build. They were to take over from 1 January 2016, but six weeks before that date it seems they did not have a proposed structure. Hence, no idea of what staff they would need, so could only ask for "expressions of interest" rather than have people apply for real positions.

This lack of preparedness is showing. Thirdly, Sydney-centred management is very difficult, and often has no understanding of the reality of rural life and work.

At the final NCGPT training weekend in Coffs Harbour, the Synergy CEO bravely fronted the meeting, but failed to effectively answer most questions. Some because he couldn't as there wasn't a plan in place; some because (it seemed) he didn't hear what was being asked.

**So how is it panning out?**

Firstly the issue of contracts. We were promised in Coffs Harbour, and again in December by Synergy officers in the Sydney office, and also by the North Coast GP Training staff (based on what they had been told), that all practices with a pre-existing contract with NCGPT would continue on that contract for the first six months of 2016.

The reality is only those that currently had a registrar continuing beyond February can continue on the old contract. Those taking on a new registrar, or a new Term, even though the agreement was made last year with NCGPT, are required to accept a Synergy contract starting February 2016. This was not made clear until trying to get onto their cumbersome website, where, as supervisor, you can't do anything until the contract is accepted. There are 18 pages of addenda and notes, in addition to the general Terms and Conditions for registrars. Synergy has labelled this as a "misunderstanding". It isn't.

While not unexpected it is disappointing that my fears here have been confirmed.

Secondly, the lack of preparedness means that two weeks after the new regime began, they still do not have phone numbers for the new local office in Ballina. I dialled the 1300 number provided in an email. This was answered by a telephonist (in Sydney) who didn't know where or who I was, nor did she know that the person I was trying to contact was in fact in the same region. She offered to email and have the local person contact me. As my contact with the training organisation is usually sandwiched between patients, when I have a few minutes, this is not an efficient way to get in touch.

When I did make the contact, the person was not familiar with the Synergy programme either. She is new in the job, and didn't know her way around the new programmes. We worked it out together. But my expectation is that the support staff should be trained and supported enough, and that they can answer basic questions with confidence. It must be very difficult for them dealing with us, without sufficient time or training to understand the system.

This is again a consequence of the lack of time and preparation by Synergy.

Thirdly the "orientation" for supervisors was inadequate. There was a meeting in Coffs Harbour on a Thursday evening, or brief videos online. The videos were simplistic and unhelpful. I pointed out that this was a three-hour drive for me, and it was impossible to attend without giving up at least half a day's consulting, and for safety's sake, should include an overnight stay.

The meeting was the only meeting between Newcastle and the Queensland border. I asked that it also be offered as a webinar. This suggestion has met the same response as my last three emailed suggestions – no response.

To ensure our continued participation, and gain our confidence, Synergy needs to keep their word. They also need to be more responsive. Two weeks in, I would grade the experience as 3 out of 10.

There is plenty of room for improvement. We must dearly hope it happens.

If they don't (or can't) lift their game, it will not only be GPs and registrars, who suffer the consequences, but ultimately our patients, even if they never get to know the name 'Synergy'.

***Ruth Tinker, Northern Rivers GP***

*Dr Ruth Tinker*

# Rural LICs - what they are, and how they work

***Dr Jane Barker** explains the value of local GP placements for advanced-level medical students*

When I first heard of the long-term student placements in general practice I wondered if and how they fitted into medical training. Longitudinal integrated clerkships, LICs for short, have now been proven to be effective learning environments for later-stage medical training.

The University Centre for Rural Health/North Coast (UCRH) has hosted students from Wollongong for the past 7 1/2 years, more than 150 students in all. Each of them has been allocated to a general practice in our area for two days a week for 38 weeks. In this four-year postgraduate program, this is effectively an eighth of their medical training.

For me the exciting part is that LICs claim what we have all known: that general practice can be a fertile learning environment, not only to teach Community Medicine but Medicine in general, that large teaching hospitals are not essential for all medical training and that there are aspects of medicine which are best learned in a general practice environment.

Medical training is complex, not least the assimilation of a very large volume of medical knowledge and its application to clinical reasoning and management. Students are required to master practical, communication and psychological skills, but also to develop what we would call the 'Art of Medicine' and all that that encompasses.

In the LIC GP program, particularly in a rural setting where GPs are involved in small hospital outpatient and inpatient care, students have the opportunity to practice all of these skills in a safe supported environment.

In addition to this the general practice environment allows the student to enhance their practice through those areas that are core to community practice - holistic care, patient centred care, continuity of care, preventative care and patient education.

Students comment regularly that they have never experienced doctor/patient relationships in the same way in a hospital setting, seeing the GPs in their many roles as physician, counsellor, mentor, holder of individual, family and community knowledge and as a valued friend.

*Medical student, Nicholas Vitko*

During their final medical years a student learns how a text book description of diseases and disease management is translated into a patient living with a disorder. This may not readily be learned from a hospital setting where the patient is safely tucked under a white sheet. Social determinants of health seen from the end of a hospital bed are purely theoretical but in general practice they are real, they are seen.

It is essential that any medical training programs support interns to be confident and competent clinicians, and this competency has become the measure of the effectiveness of medical training. There are two programs which assess intern competency in Australia - one involves assessment by hospital staff, the other interns assessing their own preparedness to practice. In both arenas the University of Wollongong program scores highly.

It interested me to investigate whether interns perceived their time in general practice had contributed to their competency and what factors particular to the longitudinal GP placements had contributed towards this. So I asked this question of 15 former students who had by then completed their internships.

**Long term relationships with GP supervisors, practice staff and patients.**

Pivotal to the GP clerkship working effectively are the relationships the student forms with supervising clinicians. The GP supervisor gives one-on-one supervision. Over time a sense of mutual respect and trust develops, with the supervisor becoming aware of the student's strengths and learning needs and supporting them to develop increasing levels of clinical competency.

In the words of one student, *"I think one of the best parts of it is that you form quite good relationships with senior clinicians. You identify different role models and mentors, doing it this way you are a lot closer to them".*

While there are times these relationships have not been ideal,. this has been a rare and has usually been quite resolvable. We have learned to better match student with practice and to better support both student and supervisor in this situation. As we get to know our students we are in a better position to anticipate issues that may arise.

Students are given long appoint-

*cont on p6*

# Rural LICs

*cont from p5*

ments with patients and talk of the importance of their longitudinal relationships. Some patients make a deliberate choice to see the student regularly. One student guided her patient through palliative care, another saw a depressed patient fortnightly over the year. This gives the students insight into disease progression, response to long term treatment and to the patient experience of living with a disorder.

Since these students are postgraduates, many with previous health care experience, their input can be very valuable, for instance a current student who is a speech pathologist with a special interest in autism, with another being a dietician with an interest in obesity.

As well as relationships with their supervisors and patients, students developed a sense of team work with in the practice and within the community. Having an in-depth knowledge of how clinical care and support are provided in the community assisted them as interns in effective discharge planning.

Said one, "When writing discharge summaries, other while other interns just cut and pasted from the notes I really put an effort into giving the GP the information they needed and indicated what support we recommended the patient required in the community."

**Developing clinical skills**

Both in general practice and small hospital EDs students had many opportunities to be the first to review patients with undifferentiated disease and to practice their clinical reasoning skills. They became competent at recognising and managing the commonly presenting cases they later managed as interns.

Feedback has included -

*"One of the greatest assets of the longitudinal placement is the ability to do parallel consulting. Once my supervisors became aware of my skill level and my learning needs they allowed me to examine and obtain histories from patients and to initiate management plans, of course with their review. That ability to go through the process independently is really where you learn."*

They became proficient at common procedural skills which reduced some of the stress suffered by many of us as interns.

*"I spent a lot of time in emergency and had a lot of independence there. I guess we were given more responsibility as students than we would have been given elsewhere. My first term as an intern was in emergency and I just felt very well prepared."*

The students really appreciated the autonomy they were given in parallel consulting and felt that more than anything this helped them to develop as independent learners, to develop their clinical skills and gave them a sense of professional identity.

*"It made me be more of an independent thinker, I remember feeling very out of my depth and out of my comfort zone. Having a patient in front of you and having to deal with their problems and decide how to manage their problems, prepared me quite well for internship. It is such a huge step acting independently."*

It is vital to the program that in their supervising of students they are not completely out of their depth or overwhelmed. As we have all become more experienced we have learned to recognise that each student will progress at their own pace and that some will be slower to take on clinical responsibility, while others at times need holding back.

**Developing professionalism and identity.**

In parallel consulting and often in the smaller EDs where there are no junior medical staff students often "act-up" under safe and supervised conditions. The students respond to this level of responsibility by taking on a professional role. They are made to feel a valued part of the team.

*"I was treated as though I was already a doctor and that was a huge responsibility I had to take seriously."*

**Advantages of rural training**

The consensus view was that training rurally was an excellent way to learn medicine for a variety of reasons, including close and continuing relationships with clinicians, less competition for access to patients, and the opportunity to extend their clinical skills by "acting-up" in the absence of junior medical staff.

Various studies in different parts of the world have confirmed that longitudinal placements in rural genera practice provide an effective training ground for medical students. One young doctor said he now sees *"medical students coming through and teaches the , and can really see the difference in the abilities of students who train rurally."*

He felt that *"their clinical skills, communication skills, and patient rapport ware superior".*

**GP supervisor feedback**

It is not a small undertaking to host medical students on longitudinal

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UNIVERSITY OF WOLLONGONG

# 'Scratching out' an artistic career

Penny Evans produces her beautiful ceramics on a kiln in the backyard of her home in suburban Lismore, on the traditional land of the Widjabul people.

As she explains http://pennye-vansart.com/ "My practice includes producing ceramics and collaged, mixed media work on paper. Each work created is unique and an evolution in my artistic practice."

Her techniques are varied, ranging across pieces thrown, pinched and coil built using raku, terracotta and white earthenware clay bodies. The technique of sgraffito (from the Italian "to scratch"), is a major focus. This is a pottery decorating technique produced by applying layers of colour/s to leather-hard pottery and then scratching off the parts of the layers to create contrasting images, patterns and texture, revealing the clay colour beneath.

Its successful use reflects Penny's cultural heritage (the Kamilaroi/Goomeroi people), her imagery drawing on the men's traditions of carving into trees, weapons, utensils as well as ground carving for ceremonial purposes, communications and storytelling.

"My concepts relate and refer to my identity through a decolonising process; learning about my Aboriginal heritage and processes of colonisation/decolonisation provide me with a rich base of material to work with," Penny told GPSpeak.

Her ancestors' homelands are to the north-west of Bundjalung country, in and around Garah, Mungindi and Narrabri.

"Professor Judy Atkinson [Southern Cross University] introduces herself as coming from the 3 I's – Indigenous, Invader, Immigrant. This also describes my heritage as an Australian. I am of Kamilaroi/Goomeroi, Anglo-Celtic & German heritage.

"For me as an artist... my primary concerns are with the history and aftermath of colonisation.

"First contact and the frontier are of particular interest to me. I have a frontier story in my family...of black and white. Aboriginal woman and freed convict man. I look back and imagine our history fleshed out with anecdotal and historical stories.

"For me our history is not the distant past. I am the culmination of it and embody it. I grew up in an education system in the late 1960's and 70's born out of denialism cloaked in a binary structure in which racism thrived and still does.

"My work is an homage to my grandfather, great grandmother and their individual life struggles as Aborigines in a climate of virulent racism in Australia. My art practice is healing and my work is often a mapping of my personal psychological and spiritual development."

Penny's superb creations are becoming increasingly popular with local collectors and in recent times have made much appreciated farewell gifts for medical practitioners undertaking placements in the Northern Rivers.

# Rural LICs

*cont from p6*

placements and I feel very grateful for those who have done so. Many of our local practices are in their eighth year of supervising students on these longitudinal placements. For the most part, the GPs involved have gained great satisfaction from supporting their students to evolve from student to junior doctor and hearing of their later progress on their medical careers. It has been particularly gratifying to know that some of these students have returned to participate in the intern program in Lismore and Tweed, and others to progress to the NCGPT program.

Others are working rurally and regionally in a variety of specialties across the country. One young doctor I interviewed has completed her GP training and happily works as a rural GP in the practice she trained in as a student - much to the joy of her GP supervisor.

For my own part, it has been a wonderful learning curve towards the end of my career to move from clinician to teacher. I have met and worked with some very lovely young men and women who give me hope as I watch them blossom and grow into the doctors of our future.

***Dr Jane Barker is Academic Lead – General Practice, University Centre for Rural Health North Coast***

# Genesis CancerCare Prostate researchers collaborate on Global Clinical Trial

Advertorial

One of the world's largest clinical trials for sufferers of the most commonly diagnosed form of cancer amongst men, prostate cancer, is underway at Genesis Cancer Care QLD centres.

ENZARAD is a randomised phase 3 trial aimed to assess the benefit of adding enzalutamide, a new type of androgen deprivation therapy, over currently available courses of androgen deprivation therapy in addition to external beam radiation therapy, in patients with high risk localised adenocarcinoma of the prostate.

ENZARAD is being led by the Australian and New Zealand Urogenital and Prostate (ANZUP) Cancer Trials Group who are collaborating with research intensive treatment centres from around the globe in the USA, Canada, UK, Ireland, New Zealand and Australia, including GCCQ here in Queensland.

Enzalutamide is not currently approved in Australia for use in prostate cancer patients but has been shown to be effective in treating late stages of the disease. The study aims to enrol 800 patients over a two year period and the opening of the study coincided with the implementation of the new TrueBeam linear accelerator at our Tugun centre, which, akin to the RapidArc machine at our Genesis CancerCare Southport Centre, offers the advantage of bowel sparing radiotherapy, with significantly reduced treatment times.

In light of 20,065 new cases of prostate cancer having been diagnosed in Australia in 2012, GCCQ's involvement in the ENZARAD trial falls in line with our goal of increasing patient access to new and emerging cancer treatments through a commitment to clinical research.

Men with newly diagnosed prostate cancer are encouraged to seek further information from their general practitioner about ENZARAD or to contact GCCQ Tugun Centre 07 5507 3600 to arrange an appointment with Professor David Christie.

# Keeping rehab patients hale and arty

Simply put, the artworks that now line the corridor of the rehabilitation and transitional care unit at Ballina District Hospital "give patients a good reason to get out of bed and take walks."

The words came from well-known local GP, Sue Page, who was representing the Board of the Northern NSW Local Health District at the opening of the latest stage of exhibited works done by all nine pre-schools and kindergartens in the Shire.

Stages 1 and 2 feature works by Ballina's primary and high schools, public and private, and have a similar focus on environmental features of the area - the sea, bird and wildlife, agriculture, the hills, and the built landscape, including the Big Prawn.

The aim of the project, as Diversional Therapist, Tracey Beck, explained, is to provide rehab patients with a visually pleasant walking 'track', distance marked, with rest points, rather than expecting them to enjoy endlessly walking down a long white corridor.

*Bringing the corridor alive... patients at the Ballina District Hospital rehabilitation unit joined hospital staff, including Diversional Therapist Tracey Beck, teacher Nikki Daley and Connor Hardy, Dr Sue Page, and hospital Executive Officer Peter Jeffree.*

The canvases for the works, and the benches at regular intervals along the lengthy corridor, were donated by the Ballina Hospital Auxiliary, an active fundraiser. They also arranged for floor markers to be positioned every five metres so patients can gauge how far they have walked.

Pre-school representatives and teachers attended the launch, as did Ballina's Mayor David Wright, who praised the initiative and thanked the schools that had participated to date, and the Auxiliary for their financial support. The response from the patients themselves? The smiles said it all, and not surprisingly, as the artworks are highly imaginative, and superbly done.

The fourth and final stage of the project will feature works from local Aboriginal artists.

# Lifestyle Medicine turns a healthy eight

***by Dr Andrew Binns***

In 2008, after a lengthy involvement with managing obesity issues at the primary care level, Adjunct Professor of Lifestyle Medicine (Southern Cross University) Garry Egger and I decided it was time to focus more on the broader issue of lifestyle-related chronic disease.

This was partly in response to the 2006 report by the Australian Institute of Health and Welfare saying that up to 70 per cent of all GP visits were thought to have a predominantly lifestyle cause.

We coined the term Lifestyle Medicine (LM) and set up the Australian Lifestyle Medicine Association (ALMA). The inaugural meeting in May 2008 was held at the University Centre for Rural Health in Lismore. The 50 attendees comprised GPs and allied health professionals from many disciplines.

The aim was to raise awareness of LM in the management and prevention of chronic disease, improve knowledge and skills in lifestyle behavioural change, and encourage more practitioners into this field. Indigenous health was to be given special attention, particularly addressing the social determinants of health. There was also to be significant emphasis on education and evidence based lifestyle medicine research.

*Lifestyle Medicine authors - Gary Egger. Stephan Rossner and Andrew Binns*

While we received strong support there were significant challenges, but later that year we held the first ALMA conference., opened by Dr Norman Swan from ABC RN's Health Report. Under Garry Egger's leadership and with co-author Swedish Professor Emeritus Stephan Rossner (Karolinska Institute Stockholm) we seconded expert contributors in the field to publish the first edition of a textbook on Lifestyle Medicine (McGraw Hill). The book has been well received.

In July 2015, ALMA was relaunched as the Australasian Society of Lifestyle Medicine (ASLM). www.lifestylemedicine.org.au With links to similar organisations in many countries, including the American College of LM and the European Society of LM, it is planned to hold the first World Conference in Melbourne this November.

We are in the process of writing the 3rd edition of the LM book for publication by Elsevier. It will be translated into many different languages, as the interest in this field is understandably growing. As populations age and chronic disease increases, driven largely by lifestyle environmental factors, the need to focus on lifestyle medicine is increasingly urgent. From every perspective, the alternative is simply unsustainable.

# 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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- **Weight loss and metabolic surgery** (laparoscopic gastric sleeve, Omega loop gastric bypass, Roux-en-Y gastric bypass)
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- **Hiatus hernia** (laparoscopic reflux surgery)
- **Liver and Pancreas surgery** (modern cancer treatment concepts with option of laparoscopic surgery)
- **Gastroscopy/Colonoscopy**

**Assoc Prof Harald Puhalla is consulting at:**

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**Southport, QLD 4215**

**John Flynn Private Hospital**
**Level 8, Suite 8B, Fred McKay House**
**42 Inland Drive Tugun, QLD, 4224**

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For more detailed information
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# Obesity in women

– risk factors and how weight loss surgery improves survival

## by Assoc Prof Harald Puhalla

Over the last two decades the rates of obese and overweight women in Australia has doubled. The NHMRC conducted a survey in 2007/2008 (published 2010) revealing that 30.9% of the female Australian population were overweight (BMI 25-30 kg/m2) and 24% were obese (BMI> 30 kg/m2). The metabolic effects of excess adipose tissue contributed to ill health independent of the increased fatty tissue itself.

The role of adipose tissue is to produce various hormones (e.g. Leptin, Resisitin) and cytocines (e.g. tumor necrosis factor alpha, interleukin-6) which have the ability to interact with many organ systems. Excess adipose tissue affects these usually helpful intercellular messengers and contributes significantly to the development of chronic diseases, affecting health and well being.

Obesity affects men and women differently, with women having the higher risk for some of the diseases listed below. In addition, they have the burden of illnesses specific to obese females.

### Type 2 Diabetes Mellitus (DM2)

Excess body fat is associated with 30% of DM2 in those of Asian descent, 80% of cases in those of European descent and 100% of cases in Pacific Islanders. With 280 new cases every day, DM2 is the fastest growing health problem in Australia. The risk of developing DM2 in overweight women is 3.9 times (male 2.4) higher compared to women who have normal weight. The DM2 risk for females dramatically increases to 12.4 times if obese, which is twice as high as obese males.

### Pregnancy

The risk of developing DM2 is higher over the age of 45. However, younger women during their child bearing years also have a 5-10% chance of developing gestational diabetes. After other factors such as a positive family history of DM2, obesity significantly increases the risk for a pregnant woman to develop insulin resistance and gestational diabetes. This in turn is associated with an increased diabetes risk later in life.

The chance for miscarriage increases for overweight women by 1.3 and in the obese by 2.2. Maternal obesity is associated with a more than doubled risk of stillbirth and neonatal death compared with women of normal weight. Obesity triples the risk of pre-eclampsia to 10%.

### Polycystic ovarian syndrome (PCOS)

Up to 15% of all women are affected by PCOS and about 70% of them are obese. Frequently, weight gain precedes the clinical features which include oligomenorrhea or amenorrhoea (70%); infertility (40% ) and hirsutism in association with hyperandrogenism (70%). PCOS is often associated with hyperinsulinism which may lead on to metabolic syndrome.

| | | Overweight -risk | Obese - risk |
|---|---|---|---|
| **Cardiovascular** | Hypertension | 1.6 | 2.4 |
| | Coronary Artery Disease | 1.8 | 3.1 |
| | Congestive Heart Failure | 1.3 | 1.8 |
| | Pulmonary Embolism | 1.9 | 3.5 |
| | Stroke | 1.2 | 1.5 |
| **Cancer** | Breast, Postmenopausal | 1.1 | 1.1 |
| | Colorectal | 1.5 | 1.7 |
| | Endometrial | 1.5 | 3.2 |
| | Kidney | 1.8 | 2.6 |

### Cardiovascular diseases

The risk of developing hypertension, cardiovascular disease, stroke or pulmonary embolism increases in overweight women and further deteriorates when becoming obese.

The leading pathology is pulmonary embolism.

### Cancer

The chances of developing colorectal cancer is increased in overweight and obese women. Renal cancer may occur more frequently in overweight women than men and increases the risk in obese women by 2.6 (men 1.8).

Obesity only slightly increases the risk of breast cancer. However, endometrial cancer occurs more frequently in overweight women with a doubling of the risk if obese.

### Mental Health

Depression is a major health problem for obese women. A dysmorphic body image frequently mediates the relationship between obesity and psychological distress. Chronic tiredness from sleep apnoea and decreased physical ability also contributes to the development of depression. The majority of women (57%) with major to severe depression are obese.

### Survival

These combined risk factors lead to a shorter life expectancy in overweight and obese women. At the age 40 years staying overweight reduces the life expectance

*cont on p12*

# Lismore comes out for Tropical Fruits festival

Once confined to the homophobic closet, the gathering of like-minded souls and sexualities known as the Tropical Fruits is now being hailed as one of the Northern Rivers' major festivals, and a major earner for local businesses at a usually quiet time for host city Lismore.

The now-annual Tropical Fruits festival, which peaks with a glitzy all-night party on New Year's eve, is not only out in the open but being welcomed by Lismore City Council, and much of the local citizenry.

It has even begun to put Lismore on the national and international lesbian/gay/bisexual/transgender/intersex map, attracting an estimated 5,000 participants, half of them from elsewhere. The financial trickle-down to the local economy from the 2015-16 events was put at around $5 million.

The highlights were a colorful street parade through Lismore, with Mayor Jenny Dowell perched in one of the classic cars, an opening event at the NORPA-managed City Hall, and sold-out performances by Scottish actor-raconteur-gay activist Alan Cumming.

*Photograph: courtesy of Brad Mustow - www.bradmustow.com*

Another mayoral link was the conspicuous presence of Michael Gates, son of a former Lismore mayor, the late Bob Gates. Perhaps better known by his drag name of Maude Boat, the professional milliner was one of the designers of the fabulous wigs used in the film and stage production of Priscilla: Queen of the Desert. An exhibition of his costume creations was staged at Lismore Regional Gallery to coincide with the festival.

Noting that the Lismore and Nimbin information centres had joined the parade, the Mayor said she would like to see other organisations getting involved, as well as a broadening of individual participants, with grandparents and children likely to love becoming involved in the fun event.

# Obesity in women - cont from p11

by 3.3 years and in smokers by 6.2 years. Obesity further significantly reduces the life expectancy by 7.1 years and in smokers by 13.3 years.

| | Overweight | Obese |
|---|---|---|
| | Female 40 y | Female 40y |
| **Non-smoker** | -3.3y | -7.1y |
| **Smoker** | -6.2y | -13.3y |

**How to treat obesity?**

Diet and exercise are the preferred methods for losing weight. However, after repeated failures bariatric surgery is an option for the morbidly obese.

Controlled studies have shown that after 10 years individuals who received non-surgical treatment for obesity gain 1.6% of their total body weight and patients who received bariatric surgery lose 16%. Women who received a gastric bypass were the most successful with a total weight loss of 25% of their total body weight.

After 15 years of follow up, the women in the surgical cohort had a significantly smaller cancer incidence compared to the women who remained obese. The same study also reported better sleep, increased activity and less depression in the surgical patients.

Bariatric surgery has long term benefits for patients with the metabolic syndrome. Newer procedures such as the Omega Loop and Mini gastric bypass are more effective (90%) than the older gastric sleeve or gastric bypass surgery (50%) for drug free management of DM2, hypertension and hyperlipidaemia.

The Royal College of Obstetricians and Gynaecologist has recently recommended bariatric surgery for obese women with PCOS since the endocrine problems inhibiting ovulation and pregnancy significantly improve.

For the right patient bariatric surgery is able to maintain long term weight loss and result in a longer, healthier and happier life.

References can be found on our website.

# Euthanasia controversy on film

by Dr Andrew Binns

When told he doesn't have long to live, Rex, the loner taxi-driver in the recent film Last Cab to Darwin, embarks on an epic drive through the outback from Broken Hill to die on his own terms in the jurisdiction where euthanasia is soon to become legal.

However, his journey reveals to him that before you can end your life, you have to live it, and to live it, you've got to share it.

After seeing this thoughtful film I attended a Q&A with legendary Australian actor Michael Caton who played the role of Rex. One of the questions asked was "is this a movie about euthanasia?" His reply was "no, it's about a journey and transcendence".

A strong theme in the film is the way a person can change at any stage of their life's journey even when they come to accept that their life is terminal (and isn't life a terminal condition?). Rex's self-transcendence from not wanting to be a burden on others as he left on his journey to ultimately abandoning that idea and returning to a new life of re-uniting with his lover, friends and community.

The characters he meets and the incidental 'palliative care' he receives from them changed his persona from being a cantankerous old man to warmly re-connecting with the people he had previously shared his insular life with. He seems to transcend into someone who has just discovered a new meaning in life. Such an existential change was spurred on by friends, acquaintances, experiences and a caring nurse.

This story is topical as the controversial euthanasia debate rolls on, peaking regularly in the public domain. For instance, public figure Andrew Denton travelled to Oregon, Belgium and the Netherlands to explore different and legal approaches to end of life challenges, and has become a strong advocate for voluntary euthanasia. Link to Andrew Denton's travels.

**Euthanasia is intentionally killing another person to relieve their suffering. It is not the withdrawal or withholding of treatment that results in death, or necessary pain and symptom relief treatment that might shorten life, if that is the only effective treatment.**


So why has this alternative become one that many in our society feel a need to promote? In the past the taking of another's life was totally unacceptable to even contemplate, except perhaps in the event of self defence. Now the populist opinion of strongly advocating legalising euthanasia has some political, albeit controversial, support.

Well respected Australian ethicist Margaret Somerville, Founding Director for the Centre for Medicine, Ethics and Law at McGill University in Montreal has strong anti-euthanasia views. Despite major advances in palliative medicine, including pain and symptom control for end of life care, she suggests there are post-modern, secular, Western democratic societies that have brought about change that we should take into account when considering the context of this debate. In explaining why this debate is now re-emerging she cites some of the following relevant trends:-

**Mystery**: we are frightened of the mystery of death and the feeling of loss of control, and convert this to the 'problem of death' that needs to be 'dealt with' to reduce anxiety – euthanasia is seen as the solution.

**What it means to be human**: we 'put down' our dog or our cat when they are terminal and suffering, so why not the same for humans as animal rights philosopher Peter Singer would suggest. Others suggest we deserve special respect because we are human.

**Mass media**: the debate tends to be media driven, with coverage given to often dramatic appeals by individuals in end of life suffering. Societal issues are difficult to compete with the populist views and get across in popular TV debates.

Denial and control of death – 'death talk': those who no longer adhere to the practice of institutional religion have lost their main forum for engaging in talking about death, except for talk around timing and controlling the way we die.

**Legalism** – legalising euthanasia seems to be heading for the legislators and courts, the "secular cathedrals". Once such talk was more for religion and the clergy.

**Materialism and consumerism**: today's excesses create a danger that people can be equated to products that have a 'use by date', and this fosters euthanasia talk.

A thought provoking anti-euthanasia essay from a physician and regular writer Karen Hitchcock in The Monthly is well worth reading:

She concludes: 'To refuse treatment is a right. To demand care is a right. It is not illegal to commit suicide – though we try to prevent its enactment. To kill or to ask to be killed is not a moral or legal right. Euthanasia is a cheap solution to the difficult and complex problem of caring for those dependent, suffering and dying'.

Where there is quality palliative care and when time is taken by GPs and doctors and nurses for the preparation of an advanced care directive a request for euthanasia is likely to be rare.

# One-in-20 Australians can't afford GPs

Although the national bulk-billing rate for GP attendances now stands at 84.6%, around 5 per cent of Australians say that financial pressures meant postponing or delaying seeking care. Moreover, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost.

Around 64 per cent of those who did visit one of the nation's 33,275 GPs reported waiting less than four hours for urgent care, while 11.1 per cent waited up to 24 hours, and 25 per cent waited longer.Overall, 20.8 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment.

The latest statistics on the across-the-board delivery of health care in Australia came in the Report of Government Services 2016, the 21st edition of the official comprehensive study of how government funding is used.

ROGS went on to report that nationally around 6,242 GP-type services per 1,000 population were provided under DHS Medicare in 2014-15, with more services available in major cities and inner regional areas than in outer regional, remote and very remote areas in most jurisdictions.

Government expenditure on general practice in Australia was $8.3 billion in 2014-15. Of this, $7.7 billion, or $328 per person, comprised fee-for-service expenditure. Nationally, there were around 2.8 million GP-type presentations to public hospital emergency departments in 2014-15.

Australian women are less well serviced by female GPs - 65.2 female GPs per 100, 000 females and 121.3 male GPs per 100 000 males.

While the figures on patient satisfaction show that GP patients rate their care experience highly, they are less happy than dental patients. This may relate to the longer duration of dental procedures, and the fact that in the main these entail out of pocket payments - the principle of the more you pay, the more you value it (dental care is not government subsidized, but often involves health fund recompense).

Nationally, 90.3 per cent respondents reported that GPs "always or often listened carefully to them", 93.3 per cent said they showed respect, and 88.9 per cent felt they spent enough time with them.Patient satisfaction with dental professional care was, respectively, 94.5 per cent, 95.7 per cent, and 95.7 per cent.

ROGS found that in 2014-15, fee-for-service expenditure by the Australian Government on general practice was $7. 7 billion, translating to a crude rate of $328 per person.

Total expenditure by all governments on primary and community health was around $29.0 billion in 2013-14.Australian Government expenditure on the PBS was around $7.1 billion, or $299 per person, in 2014-15.

**-Robin Osborne**

# Canberra introduces 'No Jab, No Pay'


From the start of 2016 the Federal Government introduced a new policy - controversial in some places, notably the NSW North Coast - called "No Jab No Pay".

This policy means that parents who have children who are not age appropriately vaccinated, who do not have a medical reason for not having vaccines, or are not on a catch-up schedule will now have their eligibility for some of their Commonwealth funded benefits cut.

The payments that may be affected include -

- Child care benefit
- Child care rebate
- Family Tax Benefit Part A supplement

The so-called 'conscientious objection' to vaccination is no longer deemed an acceptable exemption from vaccination.

North Coast-wide statistics show immunisation rates for one, two and five-year olds are less than most other areas in Australia.

The breakdown by local postcodes shows significantly higher non-vaccination rates in some places, for example, Byron Shire.

The other major policy change in this area is that children up to the age of 19 years are included, with the Australian Childhood Immunisation Register (ACIR) being extended to accept vaccines up to the age of 19.

The exemptions to this policy include -

- Anaphylaxis following a previous dose of the relevant vaccine
- Anaphylaxis following any component in the relevant vaccine
- Significant immunocompromised (for live vaccines)

Temporary exemptions include -

- Acute major medical condition
- Significantly impaired immune function that is anticipated to be of short duration
- Pregnancy (for live vaccines)

For children aged 10-19 it is recommended that a primary dose consist of :

- ADT (3 doses) 1st dose being a dTpa (or dTpa/IPV if they need polio vaccination)
- IPV (three doses)
- MMR ( 2 doses)
- Hepatitis B x 3 doses
- Varicella ( 2 doses if over the age of 14)

*Marianne Trent, Immunisation Coordinator, North Coast Public Health Unit*

- Meningococcal C

Varicella and Meningococcal C vaccines will not be included in the eligibility for Centrelink payments, but can be offered free of charge.

*The NSW Public Health Act* is presently under review regarding the vaccination requirements for children attending child care facilities, including Family Day Care.

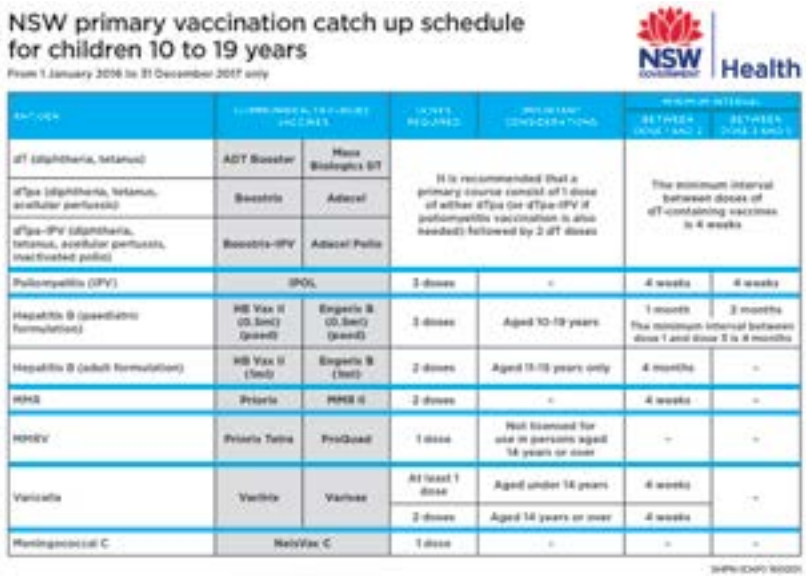
At present unvaccinated children can still attend child care facilities if their vaccine provider completes a NSW Vaccination Objection Form. This form does not get sent to ACIR and the parents are still ineligible for the linked payments.

Centrelink has been contacting parents of children up to the age of 19 and informing them if their child is not up to date with their vaccinations. If practice vaccination records are not correct, parents will be losing some of their benefits.

The easiest way for a practice to check the ACIR records is to set up a direct link to ACIR. The North Coast Primary Health Network is currently developing resources to assist practices with connecting to ACIR.

***Marianne Trent is Immunisation Coordinator, North Coast Public Health Unit***

***She can be contacted (02) 6620 7514.***


NSW primary vaccination catch up schedule for children 10 to 19 years

NSW Health

# 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.

# UCRH head leaving after 'best-ever' year

Calling 2015 the best of the seven years spent as Director of the University Centre for Rural Health North Coast, Professor Lesley Barclay AO has announced she will step down from the position shortly.

According to Prof Barclay, the past 12 months was the time when all the hopes and plans she held for The University of Sydney-backed organization came together. These included the important goal of consolidating a regional university department of rural health that works closely with the Northern NSW Local Health District to make a real difference in the quality of health care in the Northern Rivers.

Prof Barclay, who is regarded as one of Australia's leading clinician-academics, said other highlights from her time at the helm included -

- Collaborating with all tiers of government, industry and health planning bodies such as the North Coast Primary Health Network to deliver up to $10 million worth of capital works projects in Lismore, Murwillumbah and Grafton where UCRH has campuses.
- Coordinating the clinical placements of university students and longer-term medical student placements, many of whom will return to rural/regional areas after graduation. In total, around 5,000 students across 12 or so health disciplines from over 10 universities.
- Opening the Nyumbalighu Simulation Centre, which provides hands-on training for students and local health practitioners, and gives high-schoolers considering medical careers a taste of clinical education.
- Mentoring staff who have undertaken PhD studies in a range of health related fields, mostly with a regional, often an Indigenous, focus. 12 of 40-plus research students she has supervised over the last decade have been appointed associate or full professors in midwifery or maternal child health.
- Encouraging around 70 local clinicians, in both hospitals and general practice, to assist with the supervised training of students from 12 Australian universities.

She was enthusiastic about the commitment to improved pathways to care in which GP leadership, through the Primary Health Network, is playing a vital role.

"Bringing down the barriers between the primary and acute care sectors is absolutely essential, and great gains have already been made, thanks to the commitment and leadership of our local clinicians," she said.

Last year, a team headed by Professor Barclay was recognised by the Federal Government for delivering one of Australia's top-ten research projects in 2014. This team conducted extensive research on birthing practices in rural and remote communities in the Northern Territory's Top End, leading to the rollout of a model of care that delivers significant benefits for Aboriginal mothers and their babies.

The benefits include reduced infant and maternal mortality, increased birth weights and less need for medical interventions in the antenatal and post-natal periods.

Professor Barclay began her career as a midwife and went on to become an educational leader, health services researcher and systems reformer. Her many projects have improved maternal child health services in urban and remote Australia and internationally.

She is a former chair and deputy chair of the National Rural Health Alliance, an organisation of 33 peak rural health bodies, and is on the boards of the Local Health District and the Primary Health Network. She is one of the very few Distinguished Fellows of the Australian College of Midwives.

A widely published author, she has worked with bodies such as WHO and AusAID, and undertaken clinical and research work in a variety of places, including PNG, East Timor, Indonesia, and the South Pacific.

*Outgoing director of the University Centre for Rural Health, Professor Lesley Barclay AO.*

After extensive and highly valued work with maternal and child health in Samoa she was appointed a traditional Chief, one of very few foreigners to receive this honour.

Currently living in Bangalow, she is a regular early morning walker, and a keen participant in the Yogalates classes held in the village.

The Federal MP for Page, Kevin Hogan congratulated Professor Barclay for her dedicated service to the health community in the Northern Rivers, saying that the past year, and those preceding it, had seen the UCRH go from strength to strength, and consolidate its role as a major player in the local health care field.

"I wish Lesley all the very best for the future, and look forward to hearing more about her endeavours, which I'm sure will be as impressive as ever."

# "Another co-payment by stealth"

by Robin Osborne

## AMA slams MYEFO statement

Before the ink was dry on the proposal - and well in advance of a possibly hostile Senate considering the measures next year - the Government's Mid-Year Economic and Fiscal Outlook (MYEFO) statement had drawn considerable flak from key health industry bodies.

Changes to the Medicare Benefits Schedule for diagnostic imaging and pathology bulk-billing incentives would save more than $650 million over four years. The pathology incentive is currently paid at $1.40 to $3.40 per patient, with bulk-billing currently at 87.6 per cent.

Health Minister Sussan Ley said the incentive, which had cost taxpayers half a billion dollars since 2009-10, did not work, with bulk billing rates increasing just 1 per cent during that time.

The government attributed this largely to the competitive nature of the industry, which comprises of more than 5,000 pathology collection centres.

Critics of the MYEFO health proposals include the Australian Medical Association (AMA) whose president, Professor Brian Owler, called it "another chapter in the Coalition's consistent health policy since being elected – cut health funding and shift costs to patients".

Also critical of the proposed axing of the bulk billing incentives for pathology and diagnostic imaging is the Consumers Health Forum. The not-for-profit body said the prospect of a fresh cost barrier could dissuade patients from undergoing important tests.

"Many patients requiring pathology tests would face out-of-pocket costs for the first time under these budget measures, if pathology practices fail to absorb the impact of reduced Medicare benefit payments," the Forum's CEO Leanne Wells said. "Pathology tests for the most part have not attracted any out of pocket charges in the past. The Government's saving measure however poses a new hurdle in the way of patients whose GP has referred them for what could well be a significant test."

She added, "Australia needs to be strengthening its primary care services, as shown in a recent international survey and as canvassed widely by the Government's Primary Health Care Advisory Group's recent consultations on how we can better respond to people with complex and chronic conditions.

"Introducing a new price for pathology will not help improve primary care services and will discourage early diagnosis."

The AMS's Prof Owler said the axing of the bulk billing incentives for pathology and diagnostic imaging services would increase the health cost burden for Australian families, with the poorest and the sickest being hit the hardest.

"These measures are simply resurrecting a part of the Government's original ill-fated co-payment proposal from the 2014 Budget," Professor Owler said.

"It is yet another co-payment by stealth. The Government is continuing to retreat from its core responsibilities in providing access to affordable, quality health services for the Australian people.

"Cutting Medicare patient rebates for important pathology and imaging services is another example of putting the Budget bottom line ahead of good health policy.

"These services are critical to early diagnosis and management of health conditions to allow people to remain productive in their jobs for the good of the economy.

"The AMA strongly opposes these measures, and we will be encouraging the Senate to disallow them."

Other key MYEFO measures for the AMA included:

- the abolition of the National Hospital Performance Authority (NHPA) and its highly valued health reporting arrangements;
- the abolition of the National Health Funding Body and Funding Pool (the death of activity based funding?);
- on the plus side, there is extra money for the Rural Health Multidisciplinary Training Program, which supports clinical training in rural areas; and
- $93.8 million is flagged for an integrated medical training pathway for rural areas, a concept lobbied for by the AMA.

According to the government the cuts should be absorbed mostly by the competitive sector, although pathologists are already warning of increased fees for patients that may cause some to forego tests, and the closure of services in rural areas. Health Minister Sussan Ley reacted strongly to such comments, lashing out at 'large pathology companies' and saying she was 'cranky' at the claim that patients would be worse off.

Asking where the government's $500M incentive to increase bulk billing rates had gone, the minister said these companies had been doing "very nicely", and should be expected to not increase their fees.

Ms Ley said Labor's incentive payment for bulk billing of diagnostic imaging services, introduced from 2009-10 at a cost of $1.3 billion over five years, had failed to increase bulk billing rates beyond expected " natural growth".

This claim has been contested, with data indicating that bulk billed diagnostic imaging services increased from 66 per cent to 77 per cent during that period.

The proposed changes are intended to take place from July 2016, with no pathology service to attract an incentive payment, and for the bulk billing incentive for diagnostic imaging to be paid only for concession patients, such as pensioners and children under 16.

# Order in the House


Aged care across the Northern Rivers received a major boost last week with my announcement of three new Aged Care beds in Kyogle and the unveiling of construction plans for an additional 32 beds at Crowley Care Services in Ballina.

This is wonderful news for our community

The new home care places which were made possible by Federal Government funding of more than $2 million annually means our seniors can remain living in the local area and our community.

As readers know, the Northern Rivers has an ageing population and it is important to ensure they can stay in our community close to family and friends.

❖❖❖❖❖❖❖❖❖❖

Since my last column, the Federal Government has announced a comprehensive $300 million package in response to the National Ice Taskforce that is designed to reduce demand for Ice and reduce the harm it causes, while continuing efforts to disrupt supply.

Ice is playing havoc in many regional communities, including ours. More often than not, it is healthcare workers who are on the frontline.

I am particularly pleased that the Government has picked up one of the points that came out of the Ice Forum I organised in Lismore that 'local problems need local solutions'.

Our local North Coast Primary Health Network will be funded to boost local alcohol and drug treatment services and help reduce the demand for this very dangerous drug.

The package also includes significant investment in regional and rural areas where the Taskforce Report indicated service gaps and a misalignment between service prioritiesand community need.

This is an all-of-government approach that we need to tackle the problem of Ice. We cannot arrest our way out of this - it is much more than simply a law-and-order issue. We must also work to reduce the demand for the drug.

❖❖❖❖❖❖❖❖❖❖

*Page MP Kevin Hogan with Tom Fitzgerald, chairman of the Planning and Steering Committee of the Kyogle Multi Purpose Service.*

I am very happy that the new GP clinic in Coraki has opened and the provision of other allied health services in the mid-Richmond as well as in Evans Head.

I had been working with these communities and the North Coast Primary Health Network (NCPHN) to provide these health services and I am glad they are now being delivered.

The new Maria Clinic in Coraki will start as a part-time service, building up to full-time as the practice grows.

In addition to the new clinic, the Coraki and Evans Head communities can now access the services of a psychologist, speech therapist and occupational therapists thanks to a new agreement reached between the Federal Government and NCPHN.

I would particularly like to acknowledge Chris Clark and all the staff at the Primary health network in securing these services.

❖❖❖❖❖❖❖❖❖❖

Finally, I would like to thank Chris Crawford on his retirement from the North Coast Area Health Service and Prof Lesley Barclay as the Director of the University Centre for Rural Health North Coast.

They have both done an outstanding job for health services across the Northern Rivers and our community.

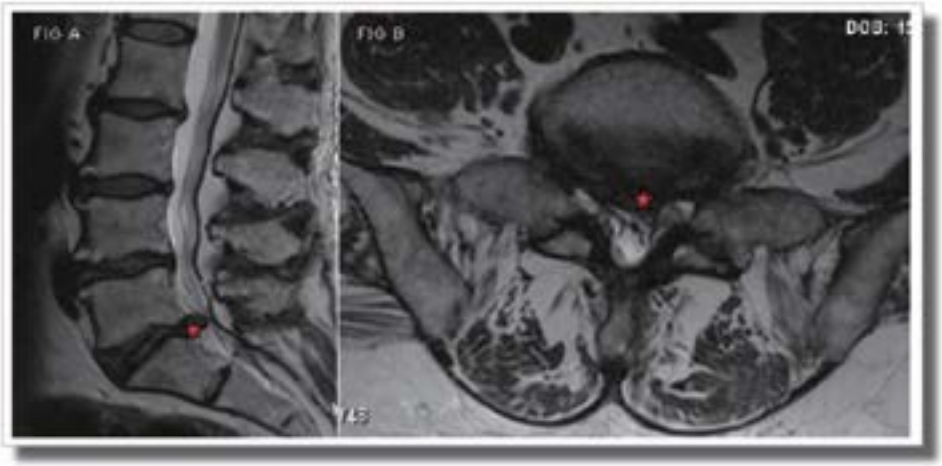
I would like to wish them both all the best for the future.

Australian Musculoskeletal Network (AMSN)

Integrating Practice With Research

# Managing and understanding disc pathologies workshop

## 16th April 2016 Byron Bay



Would you like to advance your understanding and management skills of disc lesions while earning your CPD hours?

This AMSN workshop is suitable for both medical and allied health professionals and will give more skills and confidence to manage disc pathologies correctly and well as give you some new insights as to where future imaging technologies are heading.

**Where: Byron Bay Community Centre (96 Jonson Street Byron Bay)**
**Date and Time: 16th April 2016, 13:00 - 17:00**

### Speaker - Dr Geoff Harding

Dr Geoff Harding is one of Australia's leading Musculoskeletal medical practitioners. Geoff is a noted innovator, educator, researcher and a respected clinician. Geoff is delivering a multi-professional focussed workshop for Musculoskeletal clinicians who want know and/or review their management of patients with disc lesions and related morbidity.

**www.amsn.com.au/seminars**

Email: info@amsn.com.au / Phone: +61 428 288 526

# Gender Dysphoria in Adults

*by Dr Emanuel Vlahakis, Staff Specialist in HIV/Sexual Health*

Gender dysphoria (GD) is the distress or discomfort that may occur when a person's biological sex and gender identity do not align. The term has replaced 'gender identity disorder'. This change in terminology removes the 'pathology' from being transgender, which is not a mental health condition and shifts the focus of management onto helping treat the dysphoria that is associated with being transgender.

The true prevalence of GD is unknown in Australia because of varying definitions, different cultural norms and paucity of data. New Zealand reported an estimated prevalence of 1-in-6,000, with a natal male-to-female ratio of 6 to 1. However, research suggests the prevalence is much higher than previously thought.

Individuals who identify as transgender are vulnerable, and experience higher rates of discrimination, depression and suicidality, compared with the general population. It is important for GPs to have a basic understanding of gender dysphoria as they will often be the first point of contact for these patients.

When consulting with patients who present with GD it is important to establish what name and pronoun the patients would prefer. For example, Ms Rachael Smith may prefer to be called Mr Ross Smith, and prefer 'him/his' to 'her/hers'. These simple, initial questions will establish understanding and trust in the therapeutic relationship.

**Diagnosis**

The DSM-5 has diagnostic criteria for gender dysphoria in adults. For GD to be present, a patient must have had at least two DSM-5 criteria for at least six months, and it must be identified by the patient as having caused significant distress. This generally includes any of the following:

- a significant difference between their own experienced gender and their secondary sexual characteristics
- strong desire to be rid of their secondary sexual characteristics or to prevent their development
- wanting secondary sexual characteristics of the opposite gender
- wanting to be treated as the other gender
- the strong belief that they have the feelings/reactions of the opposite gender.

Unless clinicians are experienced in the diagnosis of GD it would be important to enlist the help of a competent mental health professional for assistance. GD often presents with co-existing mental health conditions and so counselling by a clinician with experience or interest in transgender health would be recommended in the vast majority of cases. Psychologists fulfil an important support role to patients and families during transition.

They may also aid in the diagnosis of comorbid mental health conditions and can provide reports on the suitability of the individual for surgery. Finding a suitably experienced psychologist may be difficult, especially in rural areas. A psychologist skilled in the management of anxiety and depression may be the best alternative.

**Treatment**

Some patients may be happy to live in their desired gender role, but many will want to physically transition with the use of hormones, with or without surgery. It would be important to enlist the help of an endocrinologist or sexual health physician for the initiation of treatment, but once established, ongoing care can be provided by GPs.

Hormone therapy has been demonstrated to reduce distress without significant adverse psychological or physical effects. As with any medication, it is important to be aware of the reversible and permanent side effects of hormone therapy to ensure patients are fully informed. This is described well in the Endocrine Society Treatment of Transsexual Persons' Guidelines.

Surgical options for individuals who identify as transgender often refer to 'top' procedures (e.g. chest reconstruction or breast augmentation) and 'bottom' procedures (e.g. removal and creation of new genitalia). Surgical reassignment is often performed overseas due to greater expertise and lower cost. Genital surgery is often reserved for patients who have been on hormone therapy for at least one year and living in their desired role, given the permanency of the procedures.

**Changing IDs**

Successfully changing one's identity on documents is an affirmation of gender for patients, but it is often an area of confusion for doctors. The Federal Government's Australian guidelines on the recognition of sex and gender (2013) states specifically that 'sex reassignment surgery and/or hormone therapy are not prerequisites for the recognition of a change of gender in Australian Government records'. This means legal documents from Centrelink, Medicare, passports, Australian Tax Office, driver's licence, birth certificate, and any other government agency cards and records can be changed to a preferred gender.

A letter from a registered medical practitioner or registered psychologist is all that is required to change the sex. The guidelines include a section on what should be included in the letter. The forms to change the documents are easily downloaded from government websites.

In conclusion while gender dysphoria is an uncommon presentation, these individuals are often isolated and have higher rates of depression and suicide. It is important to validate and engage with the patient. Gender dysphoria often involves a multidisciplinary team, at the very heart of which is the therapeutic relationship between the GP and the patient. The GP is best placed to provide holistic and ongoing care for a person with gender dysphoria.

*Adapted from Atkinson S and Russell D 'Gender Dysphoria' volume 44, no 11 2015 p792-792*

# Cambodia's many faces

## by Robin Osborne

My recent visit to Phnom Penh, Cambodia's capital, could not have more different than arriving in the city in February 1973. A few weeks earlier, in distant Paris, the USA and Vietnam had signed the 'Peace Accords', ending America's involvement in the war and hastening the downfall of the anti-communist governments in South Vietnam, Cambodia and Laos.

I reached the city atop a truck transporting sacks of dried fish meal, a foul-smelling product that took days to leave one's clothes. I had a dog, a Labrador-like puppy I called 'Bullet' because that's what he was about to get from a batch of Cambodian soldiers.

*The customary early start for a monk outside the Royal Palace, Phnom Penh*

The truck was part of a convoy that, mercifully, had managed to traverse territory controlled by the Khmer Rouge, the guerilla force that, once in power in 1975, would evacuate Phnom Penh, implement forced labour in the countryside and slaughter all perceived enemies.

It is estimated that up to two million Cambodians died in the four years that Pol Pot's 'red Khmers' held power, supported diplomatically by a swag of countries, notably China, and including Australia.

Nowadays, the capital is at peace, striving to progress, yet driven by economic disparity - there's a Rolls Royce showroom in a city where tuk-tuks and motorbikes are the people's main transport. The more fortunate, mostly those with links to the Cambodian People's Party regime, prefer Lexus or 4WDs.

There is plenty of new high-rise, often Chinese financed, and lots of tourists, mostly on their way north to visit the Angkor temple complex but feeling obliged to visit the dark side of Cambodia's past, the 'Killing Fields' and the S21 torture centre (known as Tuol Sleng Genocide Museum).

The latter is where the Khmer Rouge sought to extract confessions from their class enemies, and eventually each other, as the revolution began eating itself, as well as those hapless foreigners, including two Australian yachtsmen, who fell into their hands.

While Siem Reap, the city close to Angkor Wat ('city of temples'), also has its killing fields - they are found throughout the land - it is the vast (163 ha) Hindu-Buddhist temple precinct that captivates the visitor.

Angkor, built in the 12th century, was the epicenter of a grand civilization that lasted 500 years before its demise. The central temple area, the largest religious monument in the world, and the Bayon, known for its multi-faced heads, fell into neglect. The ravages of tropical nature engulfed nearby temples such as Ta Prohm, the location for the Lara Croft: Tomb Raider movie.

The complex is now a world heritage site, subject to expert restoration, and charging substantial entry fees to the myriad foreign tourists who flock to see one of the great sites of the ancient world.

*The jungle continues to eat the Ta Prohm temple complex, near Ankgor Wat.*

Peacetime is kind to the Angkor complex, rivaled in SE Asia only by Java's Borobodur, allowing it to safely reveal its wonders, architectural, sculptural and botanical - the giant figs consuming Ta Prohm are perhaps the most photographed attractions of all.

Yet another reminder of human folly can be visited on the way back to Siem Reap.

The Cambodian Land Mine Museum, the work of a dedicated mine defuser named Aki Ra, gives a sobering overview of the mining and bombing of Cambodia through the decades.

There is ordnance from the US, Russia and China, with many pictures of the damage caused to people and landscape. While Cambodians put up a brave Buddhist face, the terrible past is never far away.

As an Australian aid worker put it, Cambodia is still experiencing "national PTSD", the irony being that so many of those affected were not even born during the Pol Pot time. There are remarkably few older people to be seen, most having been killed, or worked or starved to death during those dark years.

# Byron's new hospital prepares for opening

Over the past year, motorists travelling along Ewingsdale Road, Byron Bay will have seen the progress on the new Byron Central Hospital (BCH). In this time, the 6 ha site has been transformed from paddock to purpose-built hospital, and the opening day is only a couple of months away.

The landscaped site accommodates three main buildings, with space reserved to build a day surgery unit if/when a suitable service model can be implemented.

Due to the relatively small demand in the Shire for public surgical services, the Northern NSW Local Health District engaged in a 'market sounding' process to identify a surgical group, or individual surgeons, who could be interested in establishing a practice in the new hospital.


Such a model would see surgeons providing day surgery, including diagnostic procedures, to public patients booked through the NNSW LHD process, as well as private lists. A formal tender process will provide a more accurate indication of private sector interest.

The three buildings accommodate acute care (Emergency Department and inpatient rooms), Ambulatory Care (outpatients/Allied Health), Maternity (a spacious unit with large birthing baths), and sub-acute Mental Health inpatients.

One equipment highlight is the Philips 128-slice CT scanner, now in place adjacent to the ED. The CT greatly improves the level of diagnostics that can be done on-site, reducing the need for transfers to a larger hospital.

The ED is configured to function at level 3, handling more complex cases than the current departments at Byron Bay and Mullumbimby Hospitals. Again, this will enable a higher level of on-site care for the community.

When open, BCH will take over the role long served by the Shire's two district hospitals and Community Health in Bangalow, which will then close. NNSWLHD is yet to specify the future arrangements for the current hospital sites, beyond ensuring their safety after decommissioning.

Consolidating services at BCH makes the facility a 'one stop shop' - the 14-bay ED will provide 24/7 care, there will be 43 inpatient beds, chemotherapy, public dental clinic, and centralised community nursing, with a greater ability to coordinate post discharge planning with medical staff and other clinicians.

Community Nursing's NUM, Christopher Barron, told GP Speak that the service recorded 10,059 occasions of service in the past year, with most referrals coming from GPs and the hospitals. Services are generalist community nursing, including palliative care (30 per cent of Byron Shire patients die at home), Specialist Nursing and Child & Family Health services.

The space at BCH will enable more child & family clinic hours, plus immunisation and wound clinics, antenatal classes, modern birthing suites, closer liaison between midwives and Child & Family Health staff, and on-site SWISH testing by the audiology nurse.

Byron Shire clients of the service already appreciate the many, diverse supports offered, and are good adopters of care plans.

"There is a culture of health in the community," Christopher said, "Byron Shire clients have good health seeking behavior."

BCH is getting prepared to better meet the needs of these clients, as well as acute patients, with staff at the two current hospitals reporting their enthusiasm to move into the brand new facility.

***- Robin Osborne***

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# How the 'human factor' affects compliance

***by Dr Jane Barker***

As medical knowledge expands exponentially it becomes increasingly apparent how little we actually know about the miracle that is the human body. In medical school we are taught by a formula - Diagnosis + evidence based management= patient cured.

Just as simple and straight-forward as that!

Alas, this formula is inherently flawed as we very rarely cure disease, more often managing halt progression through continuing treatment..

How different if we were car mechanics working on 'patients' that do not need to have mechanical literacy for a cure to work, nor are they influenced by belief systems and past experience. Yet while cars are exceedingly simple compared to the human body, the major factor affecting their "wellness" is the same one that makes the simplistic medical formula flawed - the human factor, a term popularised decades ago by the title of one of Graham Greene's best known novels, yet too often ignored..

In 2003 the WHO estimated that only 50 per cent of chronic disease patients in the developed world followed the treatment recommendations of health care professionals. For example, studies of asthma medication regimens reported non-adherence rates between 30-70 per cent, while a study of hypertensive patients monitored through electronic pill boxes showed that 42 per cent took less than 80 per cent of their prescribed medication. Apart from reduced smoking rates we have not successfully influenced a reduction in the lifestyle factors contributing to disease, and we are being forced to realise there is an underlying complexity we are failing to address.

One of my students asked me why we bother to treat patients who are "non-compliant", this being, in her opinion, a waste of money and time, and undermining to the job satisfaction of the doctor.

However, non-adherence may come from a lack of understanding, with limited health literacy and/or language barriers having a significant influence on treatment compliance. Too often non-adherence results from a failure on the part of the health care provider to ensure the patient fully understands the clinical rationale for the management plan, and the timetable for compliance.

For too long the term "non-compliance" has been used in a derogatory way by clinicians without fully exploring the reasons behind it. The health budget, hospital bed occupancy and clinician's time are being increasingly consumed by those diseases we can treat but we cannot cure.

We are not effectively preventing these chronic diseases because causative factors are, in significant part, lifestyle choices that require patients being actively involved in self management of their own health. Lacking this patient commitment, we are only managing to delay disease progress through ongoing treatment..

In order to improve compliance us clinicians need to explore our role in supporting patients to maintain compliance, and perhaps be willing to look at compliance in a different light.

The judgemental tone of "Non-compliance" has been challenged, with WHO's calling "Non-adherence" more appropriate as it suggests a deeper understanding of the diverse reasons a patient may not adhere to recommendations.

The term "concordance" has been used to refer to clinician and patient working together to improve compliance. To me, these changes in nomenclature reflect a shift in clinician attitudes towards a more patient centred approach. It heralds a move to a more effective and holistic approach to medical care, with shared decision making, and enhanced education and support equipping patients to better care for themselves.

"Patient centred care" has become the catch cry of the decade, talked about by doctors and politicians alike. However to work effectively, patient centred decision-making needs to be accompanied by a shift in responsibility for health care from doctor alone to a patient/doctor team. Yet not all patients are comfortable with this shift, while others do not fully understand their emergent new role. Some doctors may feel that time constraints make practicing in this way impossible, although improved outcomes are both time and cost effective. As clinicians a large part of our work is to explore the health determinants which influence our patients' ability to care for themselves optimally and to support and educate them to be able to do so.

Compliance, adherence, concordance... whichever term we choose, we should rate compassion and understanding above judgement. We should be honest in our own contribution to non-adherence because that is where we can start to influence change. For instance, when a patient is diagnosed with an ongoing illness such as asthma, diabetes or cancer, the clinician is aware that the depth and nature of their therapeu-

# Compliance (cont from p25)

**by Dr Jane Barker**

tic relationship with their patient will change. This is the time to start building a deeper understanding of the patient and all the factors - physical, psychological and social - that may impact on the course of their disease and indeed on compliance.

It is a time to meet the patient at a deeper level, to hear them, to honour them and to encourage them to put trust in their own ability to self-care, with appropriate support.

The term "intelligent non-compliance" has been used to describe the situation where the patient is accepting of their medical condition and has made a conscious decision to diverge from recommended treatment.

This may come from the belief that they do not need treatment, that the treatment is having unwanted side-effects or is dangerous for them, or that other changes they are making in their life, such as weight loss for hypertension or removal of food allergens in asthma, are as effective and safer.

Sometimes this comes from an inherent mistrust of Western medicine or is influenced by cultural or religious beliefs. In this situation gentle, non-judgemental exploration and education may encourage more trust. It is sometimes hard for us as clinicians to watch the consequences of such decisions in the knowledge that disease progress may have been halted if treatment had been chosen. However, we should respect the patient's choice and accept that their decision may be "right" for them.

Sometimes recommended treatments are beyond the patient's financial or physical capacity, and we must always be mindful of this. Taking time to develop a sense of trust with our patients and to agree on treatment goals is always a good first step to better adherence.

We all react to illness in different ways and it is important for us to try to understand our patients' psychological reaction to their disease because this can have a significant influence on adherence to treatment.

Very often there is a sense of shame and grief, particularly if the patient is aware that their own choices have contributed. Sometimes there is anger and blame, whether towards self, others or even the clinician themselves.

Underlying this there is often grief and sadness, emotions that can be so overwhelming that the patient chooses denial of the disease or the severity of the disease as a way of coping. Fears around disease and its progression may cause significant anxiety or depression, so patients are unable to effectively care for themselves. Compassionate listening and exploration with the patient and use of simple psychological tools may empower the patient to feel they have some control over the course of their illness.

I liken this to travelling down a steep hill in a car - patients may feel they have no control but teaching them how to hold the steering wheel and apply the brakes helps them to feel more in control and more hopeful. At times a deeper level of psychological support is needed.

Non-adherence may come simply from lack of understanding. Lack of health literacy has a significant influence on treatment adherence. While written patient information is recommended it is of little use if the patient has low literacy skills, language barriers or the information is not given at a level they understand. Too often non-adherence results from a failure on the part of the health care provider to ensure the patient fully understands the clinical rationale for the management plan, exactly what needs to be done and how it should be done.

Let us stop being judgemental about adherence but rather develop a connection to our patients that allows both parties to truly know what the best path is for them and how we as clinicians can best support them. All of medicine is about effective partnerships, truly caring and deeply understanding.

*Dr Jane Barker is Academic Lead – General Practice, University Centre for Rural Health North Coast*

## Contacts Update

The following services have updated contact details.

### Nerve Conduction Studies

Dr Geoffrey Boyce now uses an answering service for taking bookings for his Nerve Conduction Studies.The old number is unattended for most of the week. The new number for bookings is 02 9099 9538 .

### Neurosurgical Services

Dr Ananthanababu Pattavilkom Sadasivan ("Dr Babu") consults at the Goonellabah Medical Centre twice monthly on Saturdays.

The new contact details for making appointments are:

Phone: 1300 849 162
Fax: 02 6678 0303

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