GPSpeak

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Quarterly magazine of Northern Rivers General Practice Network

Spring 2015

GPSpeak

Quarterly Magazine of the Northern Rivers General Practice Network

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Front Cover: Australian sculptural installation and performance artist, Hiromi Tango. Hiromi Tango, Art Magic: Remnant, photograph Natsky *Read more P 20*

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Who are you? - NCPHN and NRGPN

July 1st marked the first day of the next organisation to support the delivery of primary health care on the NSW North Coast. The PHN, the organisation whose name may not be spoken, (due to potential legal disputes with the long established medical corporate, Primary Health Care) has replaced Labor's Medicare Local.

The continuing restructuring of these support organisations has long been contentious and seemingly occurs with each change in government. These reorganisations are accompanied by a new name that reflects the new government's views and philosophies.

The previous General Practice networks, of which the Northern Rivers General Practice Network (NRGPN) is one of the few remaining examples, were known as Divisions of General Practice. An initial suggestion during the formation of Divisions by the Keating Labor government of 1992 was that the new organisations be called Unions of General Practice. This was soon abandoned due to concerns about possible antipathy to the name from the medical profession.

Rising above the cacophony of abbreviations, acronyms and marketing is Healthy North Coast. Their tag line, "It's all about health", resonates with those dedicated to improving medical services. North Coast PHN is a trading name of Healthy North Coast.

The NRGPN continues as a foundation member of the new organisation along with two other GP representative organisations, Mid North Coast Division of General Practice and Hastings Macleay General Practice Network.

Healthy North Coast takes advice from its Clinical and Community Councils. Due to the size of the organisation the PHN is divided into northern and southern halves. Each half shares the same boundaries as the associated NSW Local Health Districts allowing for better co-ordination of activities between the primary and secondary sectors.

NRGPN's views are made know to Healthy North Coast through the Chairman (Dr David Guest) and Clinical Editor (Dr Andrew Binns), as members of the Northern Clinical Council. However, there is no formal relationship between the two organisations at this level.

NRGPN members wishing to have input into local medical matters have several options. They can contact the Northern Clinical Council GP members. Alternatively, they may direct their concerns through the NRGPN Board via email nrgpn-board@nrgpn.org.au or by contacting any of the NRGPN Board members directly.

NRGPN members wishing to canvas views on any issue can email the members only list nrgpn-talk@nrgpn.org.au. Those seeking wider input from the community can do so through GPSpeak (email editor@gpspeak.org.au).

Membership of the NRGPN is open to all GPs (practising and non-practising) residing in the geographic borders of the NRGPN. These extend from Ocean Shores in the north, to Maclean in the south and west to Tabulam. Membership forms and the Constitution can be downloaded from the website.

The NRGPN AGM is held in November each year. A planning day for the NRGPN is scheduled for late September. It will be open to all members. It has been proposed that the NRGPN Constitution be altered to broaden the membership of the Network as well as streamlining some administrative matters. Details of the planning day will be released in late August / early September.

Members wishing to contact me about these or any other matters can reach me @zeeclor or dguest@zeeclor.mine.nu.

David Guest
NRGPN Chairman

Spring Edition

Spring has sprung, and it's time for us to prepare to spring into it - let's be more active, and shed any extra pounds gained over the winter months. Anthony Franks (page 9) shows us the way with the Bundjalung Burners, a local group of Aboriginal people embarking on a lifestyle program focussing on healthy cooking, eating and following a group exercise program with friends and family.

New GPSpeak sponsor, Associate Professor Harald Puhalla (page 17), describes the omega loop gastric bypass procedure, for those morbidly obese diabetics who cannot be controlled on medication and for whom surgery becomes a consideration and Andrew Binns (page 11) reports on new studies that show, for a percentage of patients, unhealthy lifestyle choices that lead on to chronic diseases, including obesity, and may have their roots in adverse early childhood experiences.

Even if you've got the weight under control and you're off the smokes, the booze can still get you. GPSpeak Editor, Robin Osborne, reviews the new film, Ruben Guthrie, about an advertising executive's almost literal fall from grace during a binge. Think Don Draper down under.

Former GPSpeak editor, Aaron Bertram, plays Ken a member of Ruben's AA group. Aaron holds a special place in the world of beer drinking following his **Flashdance Beer ad for Carlton United Brewery in 2006**. Aaron's article, 'Let's drink to that' (page 25), highlights the real world influence both drinking and abstaining have on our lives. GPSpeak now feels bad about inducing him to write the article for a bottle of red. Enablers are also guilty. It must be time to head off for some cognitive behavioural therapy.

Dr Kate Bolam

Family Planning gets a new doctor

Lismore and Kyogle areas now have access to a new practitioner, Dr Kate Bolam, at the Lismore and Kyogle Family Planning Clinics, which provide sexual and reproductive health services to women and youth. Dr Bolam also currently works at Prema House Medical Centre in Lismore.

The Clinics specifically encourage youth, Aboriginal and Torres Strait Islander people and people on low incomes.

Dr Bolam comes to the Northern Rivers from the NT where she has worked both as a GP and also for Family Planning NT. She also practiced as a Forensic Clinician at the Sexual Assault Referral Centre in Darwin, providing acute forensic and medical care to victims of sexual assault.

"I love having a subspecialty in sexual and reproductive health for many reasons", Dr Bolam said.

"It gives me a unique opportunity to work with all ages of clients in an area that is often quite challenging and frequently changing.

"I enjoy empowering clients to take control of their sexual health and sexual safety. I am particularly interested in the management of the menopause transition, an area that is currently under a lot of scrutiny and is difficult to navigate for many clients and doctors alike."

"Finally, but not the least, I really enjoy working with youth to improve their health and opportunities," she added. "I have moved to the Northern Rivers to be closer to family, and it is such a beautiful area...that's why so many people want to be here..."

Lismore Family Planning Clinic is at Level 3/29, Molesworth Street, Lismore, NSW 2480. Phone: (02) 6620 7660 Kyogle Family Planning Clinic is at Kyogle Community Health Centre, 199 Summerland Way, Kyogle, NSW 2478. Phone: (02) 6630 0488

Northern Rivers hospitals expanding

Major rebuilding and refurbishment work is occurring at Northern Rivers hospitals, with the $80.25M Lismore Base Hospital redevelopment well advanced towards providing improved access to a wider range of services, and additional capacity to the needs of the local community.

Construction is proceeding on the major upgrading of Lismore Base Hospital

The Stage 3a LBH redevelopment will deliver a contemporary facility in a mix of new and refurbished space, including –

- A new and significantly expanded Emergency Department
- Emergency Medical Unit
- Emergency Care / Fast Track Zone
- Expanded Medical Imaging capacity
- A new ambulance drop-off and bay
- A new renal dialysis unit

Also planned is a new 270-space car park, opposite the hospital's renovated front entrance, with work commencing in May and due for completion by erly next year. In conjunction with Lismore City Council, a resident parking scheme around the hospital will be implemented, the aim being to improve the amenity of a precinct that will not only have a medical service focus but an enhanced residential character. The Council is currently in the process of amending planning laws to enable an increased height for buildings in the area.

Upgradings have also taken place recently at Casino and Ballina Hospitals, while construction of a major new Byron Central Hospital, costed at $88M, is well under way on a greenfield site at Ewingsdale, on the approach road into Byron Bay from the northern expressway.

Aerial view of Byron Central Hospital.

The facility is scheduled for completion by April 2016, and will replace Byron District and Mullumbimby War Memorial Hospitals Services to be offered include 24-hour emergency care, 43 overnight inpatient beds, low-risk maternity, a new 20-bed, non-acute mental health unit, enhanced medical imaging, including CT, dental service, satellite chemotherapy, and ambulatory care.

HealthPathways is the answer

HealthPathways began in New Zealand and is an online tool designed to help GPs assess and manage conditions. In addition there is information about local referral options. It is now used in Australia with about 13 sites working on their own pathways. At Western Sydney we began our journey in 2012 starting with the diabetes pathways. Our first batch of pathways went live in November 2013 and we now have over 100 pathways on our live site and 100 more almost ready for publication.

Why is HealthPathways different?

Rather than a guideline, HealthPathways is an agreement between primary and secondary services on how patients with particular conditions will by managed in the local context. Those involved include GPs, specialists, allied health workers and community health workers. Each area tailors the content of the pathways to reflect local arrangements and opinion.

Who uses HealthPathways?

The target audience for HealthPathways is primary care physicians responsible for managing patients in the community and for initiating referrals to other services including hospital clinics. Our GP Registrars love HealthPathways as they find it extremely useful for accessing local referral options as well as an invaluable study tool when studying for their FRACGP exams. In Western Sydney we have also provided a logon for medical students from 3 universities – The University of Sydney, The University of Western Sydney and Notre Dame so that they can use HealthPathways as s study resource. Many pages are also useful for Practice Nurses as well as hospital clinicians

Why HealthPathways?

As a GP I often feel overwhelmed by the number of guidelines available. Most are very useful but are often lengthy documents and it can take some time to find the information that you are looking for. In addition they are on different websites and have different formats and structures. Some require subscription.

HealthPathways is a unique resource where information about multiple conditions is available on one site with no user fee. It is accessible via desktop, laptop, tablet and phone. The site is user friendly and the pages are structured in a consistent format so that information is easy to locate. The advice is concise with the use of drop down boxes to include additional information without making the pages long and difficult to navigate.

Dr Michelle Crockett

Pages are divided into clinical and referral pages. Text on the clinical pages is written using evidence based guidelines and local specialist opinion. The structure of the pages - 'Assessment', 'Management', 'Referral' and 'Information' make it easy for the GP to locate the information they need. The information section contains 'Clinical Resources' that are used if the GP wants to read more about the condition and will take you to an external web page that opens in a new window. Patient information allows the clinician to provide information about the condition that is written for patients. Some pages contain references for facts contained in the pathway.

Referral pages are extremely useful! Included on these pages is information about both private and public referral options. Who hasn't spent ½ hour on the phone trying to track down an appropriate doctor or clinic to refer a patient to? HealthPathways has the information needed to find the appropriate service. This includes telephone numbers to speak with the specialists on call at local hospitals, lists of private specialists, as well as hospital and community clinics. Clinic information such as inclusion and exclusion criteria, how to refer, what is available, how the appointment is organised is included on the page. Everything the GP needs to know about what is available and how to access it!

In Western Sydney the process of documenting the services available has led to the identification of issues with and gaps in services, so that services are being redesigned to meet the needs of the community. This has opened dialogue between secondary and primary care so that we have a better understanding of each other and can work together to improve health services for the entire community.

HealthPathways and Western Sydney

Western Sydney has a population of over 850,000 with areas of significant disadvantage. Need for hospital care and the incidence chronic disease are growing at a faster rate than our population. We have 4 major public hospitals as well as a tertiary children's hospital in our area. Having an efficient, cost effective health system is essential to our future. HealthPathways is an integral part of our health plan for the future. It is embedded into our Linked

(cont on P6)

HealthPathways - the Western Sydney experience

cont from p5

Electronic Health Record, our online-shared care plan for our patients.

Our most visited HealthPathways page is the physiotherapy referral page. This page contains no clinical information, only referral information about hospital physiotherapy clinics. The average session time per visit is about 6 minutes and almost 75% of users are return users.

Personally I find the site has multiple uses. Specific pieces of information can be located quickly during the consultation. For example I was able to locate the contact tracing time for an STI in less than 1 minute. At other times I read an entire page to familiarise myself with a condition I do not see often, review a condition or check that I have not forgotten anything important for a specific patient. Looking for referral information, especially at the local hospitals, has been demystified!

Pathways are reviewed at varying intervals to ensure information remains up-to-date and accurate. Alerts about major clinical changes are distributed throughout the HealthPathways community electronically. Pages such as influenza are updated yearly and most other pages every 2 years.

HealthPathways is password protected so access is restricted to health professionals. We are currently working on a patient site as part of HealthPathways that will have all of the patient resources available for patients to access. This site will not be password protected.

Some unexpected benefits

Working collaboratively with other health professionals has resulted in unexpected benefits. While most GPs have worked in the hospital system, many specialists have never worked in general practice. Working together has improved understanding of the issues and challenges faced both in general practice and hospitals and allowed discussions around potential solutions. Hospitals and other service providers are able to provide information about their service so that GPs have access to information on the full range of services available in their local area.

Communication from general practice has improved in areas where clinic details have been included in the referral section of HealthPathways and the number of inappropriate referrals has reduced. Discussions have begun around improving communication from the hospital to general practice including electronic communication and sharing of pathology and radiology results. Groups who rarely communicate but work in the same area are able to come together to discuss their services with a goal of better utilisation of the services available. Service redesign has occurred resulting in reduced waiting times at our diabetic clinics and the referral of patients back to general practice for long term management.

'HealthPathways is the answer!'

How to use HealthPathways – save time and improve patient outcomes

Like all new things getting into the habit of using something is the first hurdle. To get the most from the tool I suggest reading through the 'Using HealthPathways' section of pages. Learn how to use the search function and familiarise yourself with the layout of the different types of pages. This will allow you to locate the information that you need quickly. Have a link from your desktop to the site and open it at the start of each session. Encourage other staff such as Practice Nurses to become familiar with the site and its content.

There is a feedback button on each page that allows the user to send feedback about the content of any of the pages. You also have the ability to email a link to a page.

The Future

With over 700 pages available to be localised, HealthPathways is a fabulous and extensive resource for GPs. The ongoing dialogue between the primary and secondary care will continue to break down barriers with the aim of removing the silos in the system, to improve the patient journey through the health system. The ultimate goal being: the right care, at the right time, by the right person in a system that is integrated, streamlined, cost effective with improved patient outcomes.

For Western Sydney, in the words of my of my esteemed predecessor and 2014 RACGP General Practitioner of the Year, Dr Michael Crampton, **HealthPathways is the answer!**

Dr Michelle Crockett is the Clinical Lead and Senior HealthPathways GP Clinical Editor for the WentWest Primary Health Network's HealthPathways project.

Partners commit to tackle Aboriginal health challenges

by Robin Osborne

Launching the Northern New South Wales Integrated Aboriginal Health and Wellbeing Plan 2015-2020 were (l-r) Heather McGregor Director Aboriginal Learning Circle North Coast TAFE, Steve Blunden, CEO Bulgarr Ngaru Medical Aboriginal Corporation Richmond Valley, Inspector Nicole Bruce Richmond Tweed Police Local Area Command, Chris Crawford CE NNSWLHD, Deborah Monaghan NNSWLHD Board Member and Chair of the committee who developed the plan, Mark Moore CEO Bullinah AMS, Kym Langill FaCS, Scott Monaghan CEO Bulgarr Ngaru Medical Aboriginal Corporation, Vahid Saberi Chief Executive North Coast Primary Health Network.

A broad partnership of health services, Aboriginal community representatives and state government agencies has committed to addressing what a newly released health plan calls "large disparities in estimated life expectancy and health outcomes between Aboriginal people and non-Aboriginal people in Northern NSW."

The partners came together in early August to launch the three volumes of the Northern New South Wales Integrated Aboriginal Health and Wellbeing Plan 2015-2020 at the Lismore headquarters of the Northern NSW Local Health District.

The event was hosted by Deborah Monaghan, LHD Board member and chair of the committee that oversaw the report's development. Attending were Aboriginal Elders, Aboriginal Medical Services, North Coast Primary Health Network, Family and Community Services, Aboriginal Learning Circle - TAFE, and Northern NSW Police.

The plan lists the challenges and collaborative priorities for the LHD, and other key agencies, in improving the health and wellbeing of the 13,660 Aboriginal people across Northern NSW (4.7 per cent of the population) over the next five years.

It includes a detailed profile of Aboriginal health and wellbeing in the Aboriginal communities comprising the Bundjalung, Yaegl, Gumbaynggirr, and Githabul Nations.

Vol 1 overviews the development of the plan, which took 12 months and included extensive regional consultations with Aboriginal organisations and individuals. It also lists the goals and strategies for building partnerships and better targeting service delivery. These highlight the social and cultural links with improved health outcomes. Strengthening the Aboriginal workforce is another focus.

Vol 3 is a resource listing services currently available and those responsible for managing them.

Vol 2 is where the sombre statistics on Aboriginal people's health circumstances are described. Compared to the non-Aboriginal population, they have –

- three times the rate of low birth weight babies (14 per cent having low birth weight), and more than twice the rate of premature births (13 per cent compared to six per cent);
- nearly three times the rate of hospital admissions, including four times the rate of hospitalisations for diabetes, 2.6 times higher for respiratory disease, six times higher for COPD and twice for asthma, twice the rate for cardiovascular disease, 2.5 times the rate for acute mental health, and three times the rate for preventable dental conditions;
- a higher incidence of, and lower survival rates for, cancer.

And so it goes on, although it will not for too much longer, if the analysis and recommendations in the plan are appropriately acted upon by those involved with its development. This includes Aboriginal people themselves, too many of whom are suffering from preventable diseases resulting from, or exacerbated by, factors such as tobacco use or high body mass issues.

North Coast Primary Health Network CE Vahid Saberi called the plan "a very significant event for the region…a turning point", mentioning it in the context of the Mabo decision and the 2000 walk for Reconciliation across Sydney Harbour Bridge.

LHD CE Chris Crawford noted that, "Through the consultation process, Aboriginal communities repeatedly raised concerns about substance abuse, sexual health and communicable disease, maternal and child health, chronic disease, and the lower life expectancy with Aboriginal people."

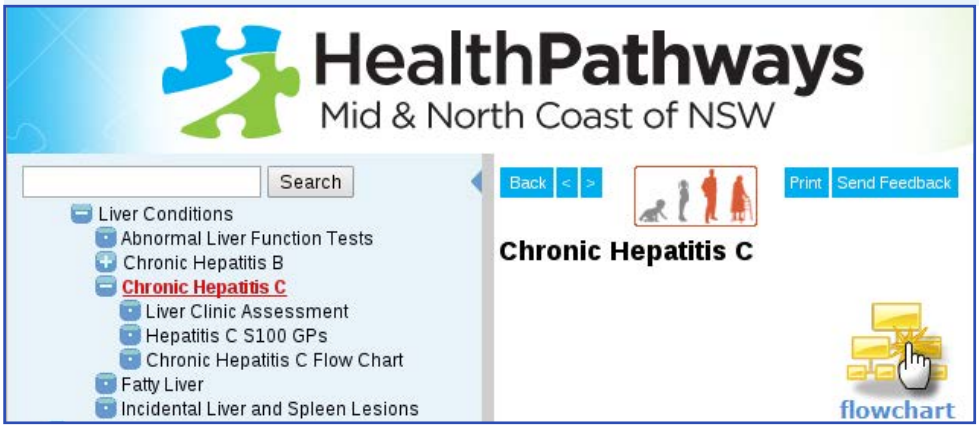
He added, "However, the poorer Aboriginal health status is not just about health. It is also about the provision of housing, drinking water, and sewerage services for local residents."

Hence the inclusion of a range of other government agencies in the initiative.

Deborah Monaghan writes in her introduction that, "The Plan presents an opportunity to build on partnerships and to work together to develop services in a way that addresses the needs of a growing Aboriginal population.

"I am confident that if we work together this Plan will help us to improve the health and wellbeing of the Aboriginal people living in Northern NSW."

Northern Rivers Health Pathway for Hepatitis C



The new treatments for hepatitis C, likely to be passed by the **PBAC** early next year, will not change the **Northern Rivers Health Pathway,** at least in the short term.

The pathway is designed to give GPs a quick guide to the management of hepatitis C patients on the North Coast. A brief overview and flowchart are sufficient to determine if patients would qualify and benefit from referral. To save time the pathway has a list of recommended pre-assessment blood tests.

Referral to the Lismore Liver Clinic will involve more detailed assessment of the liver. It has been **using its Fibroscan** for 18 months to assess the density of the liver and hence the severity of the disease. This is offered to all new patients.

In a recent talk Dr Mark Cornwell, Director of the Lismore Liver Clinic, noted that the new drug regimens, which do not include interferon, have fewer side effects, are more effective with cure rates in the high 90% range and a course of treatment can be completed in as little as 3 months for some Hepatitis C genotypes.

The talk was sponsored by the **Australasian Society for HIV Medicine (ASHM)** with an unconditional grant from **Gilead Pharmaceuticals**. The **GPs and Hepatitis C booklet** from ASHM gives a comprehensive review of the topic.

Members of the Northern Rivers can access the **portal** using the username and password found in the members section of the NRGPN website.

Comments on any pathway can be given using the "Send Feedback" form accessible via the link in the top right of page. General comments on the implementation of health pathways on the North Coast can also be sent to **info@nrgpn.org.au.**

Bundjalung burners are happy "losers"

A group of Aboriginal people from local communities has recorded significant health and fitness gains from a program that saw them become the first Northern Rivers team to participate in the annual, statewide 'Team NSW Knockout Health Challenge'.

In addition, they came in the top fifteen for NSW, a remarkable performance according to Northern NSW Local Health District's Aboriginal Chronic Care Officer, Anthony Franks.

The challenge is a NSW Health initiative, and the local Bundjalung Burners group from the Jubullum (Tabulam) - Casino – Kyogle area were supported in their endeavours by a partnership comprising Bulgarr Ngaru Medical Aboriginal Corporation Richmond Valley Clinic, Casino Community Health, Northern NSW Local Health District, and Ballina-based Solid Mob.

Mr Franks said he was delighted by the uptake of the program by a diverse group of community members, female (mostly) and male, all aged over 18 years.

"They showed great commitment over the duration of the three-months-long program, which started with a health screening and assessment, healthy cooking/eating sessions and chronic disease education sessions, and included a fitness regime individually tailored to each participant and supervised by coach Mark Roberts.

"There was ongoing support from medical and community health staff at the various health services. This is continuing and being extended to others who, for various reasons, were not able to join the Challenge but feel inspired by the involvement of family members and friends," Mr Franks explained.

A key focus of the broader program is ensuring that Aboriginal people with, or at risk of, chronic disease have access to culturally appropriate rehabilitation programs. The initial focus is on the Casino, Jubullum and Kyogle communities who are currently not accessing mainstream chronic disease programs on a regular basis.

The objectives include increasing social participation and cohesiveness, decreasing participants' weight and fitness, increasing activity in the home, boosting knowledge, skills and confidence in shopping, planning, preparing and cooking of healthy meals, and improving health outcomes in partnership with participants' GPs.

Training and support for the Bundjalung Burners included a range of dietary, medical and lifestyle advice, along with exercise routines such as walking and running, weights, theraband exercises, and stretching. Participants were assessed at regular intervals during the program in accordance with weight and waist measurement criteria, and their performance in 400m walks, push-ups and sit-to-stand repetitions.

In almost every case, participants were found to have reduced their weight - in one case by five kilos - with physical performance almost invariably improved as well.

"Just as importantly, a number of participants are exercising at home as a result of the program, which also inspires others, and have managed to decrease medication intake through participating in this program," Anthony Franks told GP Speak.

Feedback from participants included - "This program highlights the chronic health problems that our mob face and it's a great way to address these issues"; "It was an awesome program, communities need more programs like this"; "Thanks to the program and management from my GP I am now off chemotherapy and steroid treatment to treat my arthritis"; and, "Although I only lost 200g according to the scales, I lost 13cm off my waist."

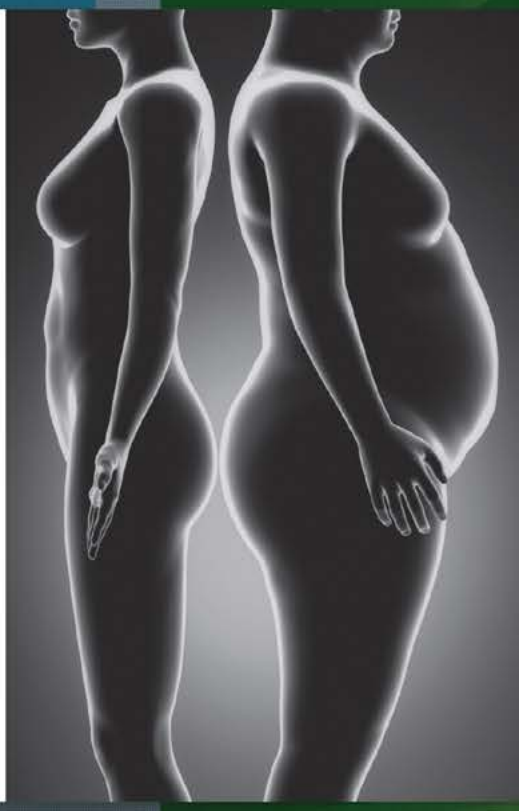
This year's program commenced at the start of the rugby league season, around April, and ran until June. Mr Franks is confident that another group will be formed in 2016, most likely with greater involvement, now that the word has spread. He also expects they will finish further up the state ladder in this milestone health initiative run by and for Aboriginal people.

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.



Services:

- **Weight loss and metabolic surgery** (laparoscopic gastric sleeve, Omega loop gastric bypass, Roux-en-Y gastric bypass)
- **Cholecystectomy and bile duct exploration** (gallstones, advanced laparoscopic bile duct surgery)
- **Hernia** (laparoscopic repair of abdominal wall, inguinal and femoral hernia)
- **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:

Pacific Private Hospital
Suite 3, Level 6, 123 Nerang St,
Southport, QLD 4215

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

Regular operating lists in **Allamanda, Pindara** and **John Flynn.**

For more detailed information
www.generalsurgerygoldcoast.com.au

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Childhood trauma can trigger later life obesity

Many obese/morbidly obese Americans have been identified as suffering physical, sexual or verbal abuse, or other adverse trauma, in their childhood, according to a milestone study by the US Centers for Disease Control and Prevention (CDC).

The Adverse Child Experience (ACE) Study found that living with an alcoholic or drug taking parent or a mentally ill family member, or experiencing rape or other physical assault, can also be triggers for weight gain in later life (as well as other chronic diseases). The prevalence of this connection is only starting to be recognized by clinicians, including GPs and counselors, with presentations suggesting that the Australian experience parallels the USA's.

It is estimated from this study and other data that about 8 per cent of obese people were sexually abused as children. It is well known that food – like the more evidently harmful tobacco and alcohol - can offer comfort by temporarily relieving stress, bad memories, shame or guilt. This applies even when obesity becomes uncomfortable or even life threatening. Yet many people who are obese still look at eating as a solution not a problem. For these unfortunate people our well intentioned advice on diets, nutritional advice or increasing exercise may fall on deaf ears and be unhelpful.

It is worth noting that for obese people who did not have childhood trauma, conventional weight loss measures involving nutritional and physical advice, or even bariatric surgery for more severe cases, are more likely to play a constructive part in a wellness pathway. That said, there are many reasons for obesity, although ACE is a more common one than previously recognised.

The research began in 1985 when Vincent Felitti, the chief physician of Kaiser Permanente's Department of Preventive Medicine in San Diego, was puzzled as to why 55 per cent of the 1500 people who enrolled in his weight loss clinic every year left before completing the program. Most had been losing weight when they dropped out.

Dr Felitti interviewed 286 of these patients and found a pattern showing most had gained significant amounts of weight quite quickly at about the time they became sexually active. They may have then stabilized their weight, and even if they lost weight they regained it quickly, sometimes exceeding what they had originally lost.

In 1990, he presented his findings to the North American Association for the Study of Obesity in Atlanta. The study was denigrated by members who told him he was naïve to believe his patients. However, Dr. David Williams, then a CDC researcher, was intrigued and advised him in the interests of credibility to do a much larger study on the relationship between childhood trauma and obesity, and introduced Felitti to Robert Anda, a medical epidemiologist at the CDC. Dr Anda took six months to research 15 years of child abuse literature, and selected 10 risk factors to measure.

Along with physical, verbal and sexual abuse, and physical and emotional neglect, five other factors seemed significant. These were having a parent who was an alcoholic or diagnosed mentally ill, a family member in prison, a mother who was being abused, and losing a parent through abandonment or divorce. Anda and Felitti decided to call their research the Adverse Childhood Experiences Study (ACE Study).

The research was done in 17,000 mainly white, middle and upper class people most of who had jobs and education. They concluded ACEs were a major determinant of many chronic diseases, not just obesity, and this is a major public health impact that will be the topic of a future article in GPSpeak.

Disclaimer: Individuals pictured are models and are used for illustrative purposes only.

Nine Ways To Avoid A Tax Audit

Peter Morrow (partner) **Kris Graham (partner)**

The Tax Office annually releases its compliance program to let taxpayers know which areas will be their focus for the year. To provide some perspective, they expect to data match over 640 million transactions to tax returns this year.

Below are nine common ways to ensure you are not subjected to an ATO audit:

1. Have financial performance that is in line with industry standards

As a matter of course the tax office will statistically analyse your tax return. If your statistics are inconsistent with averages for your industry, if may be an indicator of tax issues such as unreported income, transfer pricing and other issues.

2. Pay the correct amount of superannuation for your employees

If your employees complain to the ATO that their employer has not paid them the right amount of superannuation (or not paid it on time), you are more than likely to get a review from the ATO.

3. Minimise variances between tax returns and BAS

Large variances between the information reported in a tax return compared to Business Activity Statements are likely to trigger an ATO review.

4. Lodge your tax returns on time

A good compliance history will improve the ATO's perception of your business. This includes lodging income tax returns, BAS, PAYG Summaries (Group Certificates), fringe benefits tax returns plus the on-time payment of any tax liabilities

5. Don't consistently show operating losses

Losses in 3 years out of the last five are likely to trigger indicative of problems. There may be genuine reasons, but the ATO is likely to want to investigate these.

6. Ensure all transactions are included

The ATO receive data from the Banks, Stamp Duties Office, Land Titles Office, Centrelink, Share Registries and the RTA, and matches this with your tax return. If an enquiry is triggered because of missing data, the audit will generally cover include income tax, Capital Gains Tax, GST and FBT.

7. Profitability fluctuations are a possible indicator.

The ATO will compare your tax returns year-on-year. Big fluctuations in financial position or particular line items in the tax return can trigger an inquiry from the ATO.

8. International transactions

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

9. Avoid Publicity

Not all publicity is good publicity when it comes to tax audits!! A major transaction or dispute that is reported in the media will undoubtedly be seen by the ATO. Many business owners are selected for an ATO review after the sale of a high value asset is reported in the paper.

Should you require assistance in dealing with a tax audit or review, or would like further information about audit triggers, please contact Peter Morrow or Kris Graham at Thomas Noble & Russell on (02) 6621 8544

Birthing research puts UCRH head in Australia's top-ten

The director of the University Centre for Rural Health (UCRH), Professor Lesley Barclay AM, has won an accolade from the federal government for leading one of Australia's top-ten research projects over the past year.

The Ten of the Best Research Projects 2014 were selected for their innovativeness and potential to make a difference to the lives of Australians and people worldwide.

The names of those making the exclusive list were announced recently by Health Minister Sussan Ley: "These research stories give us a glimpse into the next generation of treatments and medical devices that will make a difference to people's lives."

Professor Barclay's team conducted extensive research on birthing practices in rural and remote communities in the Northern Territory's Top End. This led to the rollout of a model of care that is delivering 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," said Professor Barclay who began her career as a midwife.

"At present, Aboriginal and Torres Strait Islander women still have a higher maternal mortality rate than women in Sri Lanka or Malaysia, with twice as many Indigenous babies (11 per cent in total) being of a lower birth weight than the general Australian population. "

The research was supported by the National Health and Medical Research Council (NHMRC). The work started when Professor Barclay was at Charles Darwin University and was completed at the University of Sydney.

"While most Australian mothers in urban centres have access to high quality maternity and infant care, those living in rural and remote Australia aren't so lucky, and Indigenous Australian mothers in these locations are at a particular disadvantage," Professor Barclay added."Based on my own experience and the research findings, it was clear that too many women were missing out on proper evidence-based care, while the care they did receive was delivered in ways that weren't respectful to women, and were not family-centred."

The research was carried out in two large remote communities in the Territory's Top End, and their regional centre. It included lengthy observations, dozens of interviews and the study of hundreds of mother infant records.

The results led to a range of improvements, the most significant being the Midwifery Group Practice (MGP) model, which provides a continuity of care where one known midwife provides pregnancy, birth and post birth services.

Professor Lesley Barclay AM, director University Centre for Rural Health. Photo: Arthur Mostead.

"Before the MGP model was implemented, local women were seen by numerous carers across pregnancy and birth, receiving inconsistent advice and not developing rapport with a care provider," Professor Barclay explained.

The research team found that the MGP helped improve clinical effectiveness and quality of care for women, with a saving of around $700 per mother-infant cohort.

While the care provided to infants living in those communities is still not satisfactory – for example, attempts to provide skilled nurses for infants failed - the partnership between researchers and health systems leaders has made a huge difference.

Professor Barclay and her team are now working to develop the Australian Regional Birthing Index, a version of a calculation designed by Canadian researchers. This tool estimates the level of maternity service required for a given regional population based on its characteristics and isolation. This research is also funded by NHMRC.

Nerve Conduction Studies in Lismore

Dr Geoffrey Boyce has retired and closed his neurology practice in Lismore. However he continues to offer a nerve conducton service from his rooms at 23 Dalley Street LIsmore, opposite St Vincent's Hospital. The service currently operates on alternate Fridays.

LISMORE SPECIALIST CENTRE

Appointments can be made on 02 6621 8245 and clinical information can be faxed to 02 6621 8237.

Small-town GPs more likely to move on – new study

A detailed study of 3,906 GPs – nearly one-in-five of the national GP workforce – has revealed that small-sized towns face the highest risk of GP turnover, with key influencing factors being GPs working in a location for less than three years, being contracted or salaried employees, or international medical graduates.

While remote and very remote GPs had the highest mobility rate, this group was not at significantly greater risk of leaving non-metropolitan practice completely. Rural GPs practising in towns of less than 5,000 residents, and in towns of up to 15,000 residents, were most likely to move to metropolitan areas.

Overall, annual location retention rates were 95 per cent in regional centres, 90 per cent in small rural towns, and 82 per cent in very remote areas.

The four-year study drew on data from the **Medicine in Australia: Balancing Employment and Life (MABEL) survey**, conducted within the Centre for Research Excellence in Medical Workforce Dynamics. MABEL is Australia's national longitudinal survey of doctors, and collects similar data in annual waves from mostly the same panel of doctors (https://mabel.org.au).

Geographical mobility of general practitioners in rural Australia was reported in the Medical Journal of Australia by **Matthew R McGrail and John S Humphreys.**

The authors regard GPs as "Key to improving the poorer health status that characterises people in rural areas [and to] ensuring equitable access to appropriate health care… this requires recruiting and retaining an adequate supply of appropriate health workers, which is known to be difficult in rural and remote areas."

The younger age of GPs was found to be "a small predictor of increased mobility" while sex and family status were found not to be a factor.

The Monash University-based authors said that while the chance of moving to a non-metropolitan area was 1 in 75 for metropolitan GPs, the risk of losing non-metropolitan GPs to metropolitan areas was 1 in 31.

"Of the 271 GPs who moved within non-metropolitan Australia, 77 moved to regional centres (population over 50,000), but only 24 left regional centres for a smaller rural or remote location. A further 18 GPs moved from a rural to a remote location and 35 moved from remote practice to small or large rural locations.

"Understanding GP mobility is important because of its impact on workforce availability — both in the origin area (place from which the doctor moved) and the destination area," they said.

"Considerable investment is made by governments into health programs specifically oriented towards improving the recruitment and retention of doctors in rural areas, with the goal of maximising movement into and minimising movement away from rural areas," they added.

Order in the House

Kevin Hogan
MP for Page

As any health professional would know, it is often difficult to attract GPs to regional and rural towns.

This is why the Federal Government recently overhauled its GP Rural Incentives Programme (GPRIP), which means towns like Casino, Coraki, Evans Head, Kyogle, Iluka and Yamba will now receive increased subsidies to attract and retain doctors.

The new GPRIP system delivers a fairer system for smaller towns; redirecting money to attract more doctors to smaller towns that have genuine difficulty attracting and retaining doctors.

It made no sense that under the previous government's system, some $50 million a year was being used to pay incentives for doctors to live in 14 large regional cities, including Townsville (population 175,000), and Cairns (population 145,000).

It makes much more sense to use the GPRIP funding to attract doctors to where the greatest shortages are - small rural and remote communities, not big regional cities.

This means bigger incentive payments will go to doctors who choose to work in the areas of greatest need.

The highest incentive paid to work in remote Australia will jump from $47,000 a year to $60,000 a year. The maximum incentive to work in a town of less than 5,000 in regional Australia will increase from $18,000 to $23,000.

Other changes include:

- Doctors will be able to take leave from a rural practice for up to five years with no loss of incentive status on their return;
- Four existing programs have been streamlined into a single GPRIP retention payment;
- Doctors will need to stay in a rural or regional area longer - two years up from the current six months - before they receive the incentive.
- Doctors in remote areas will receive incentive payments after a year.

Great news for people with melanoma with the Federal Government last month announcing it had listed the breakthrough drug Keytruda on the Pharmaceutical Benefits Scheme.

This will improve quality of life for more than 1,000 patients and make the $150,000 per year treatment affordable.

It complements $1.3 billion from the 2015/16 Budget for other melanoma medicines as well as drugs to treat breast cancer, blindness and shingles.

Treatment using pembrolizumab (Keytruda®) currently costs patients with metastatic melanoma up to $156,130 per year without taxpayer subsidy through the PBS.

Patients will now pay $6.10 if they are concessional patients or $37.70 for general patients.

Shortly after my election, I started lobbying the then health minister to find $3 million to upgrade the Emergency Department at Casino and District Memorial Hospital.

Late last month, I delivered on my commitment with the opening of the newly upgraded Emergency Department.

It now has new treatment and resuscitation bays, a new triage area and staff room, and improvements to the ambulance entry area and waiting rooms.

Casino's new Emergency department and the $4.5 million upgrade of Ballina Hospital will have a two-fold effect – it will give each community better health facilities, while easing pressure at Lismore Base Hospital. In short, there will be long-term benefit for locals, hospital staff, visitors to the region and new residents.

I would like to thank all the staff at Casino Hospital for their ongoing professionalism throughout the construction. I think they will agree it has been worth it.

AMSN's EduVentures

Australian Musculoskeletal Network (AMSN)

The Border to Bay Walk

Physician Heal-thy Self Eduventure

5th - 8th November 2015

Australasian Society of Lifestyle Medicine

AMSN in collaboration with Australasian Society for Lifestyle Medicine (ASLM) invite you to join us on an Eduventure, 5th-8th November 2015, that focusses on you.

Our team led by Dr Caroline West (GP) and Garry Egger, will provide you with a tool kit for self-care and surviving your Clinician-based lifestyle.

We beach walk from NSW Border to the Byron Bay Lighthouse (approx. 60Kms) over three days while staying at the beautiful Mantra on Salt at Kingscliff. We revisit the Lifestyle Medicine you need to practice on yourself so you are equipped to care for others.

There is no better gift to your family and patients than a healthier you. A healthy self is an essential component of good, enjoyable and sustainable practice.

Japan EduVenture

7th - 10th 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.

www.amsn.com.au/seminars

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

A gut feeling to cure diabetes

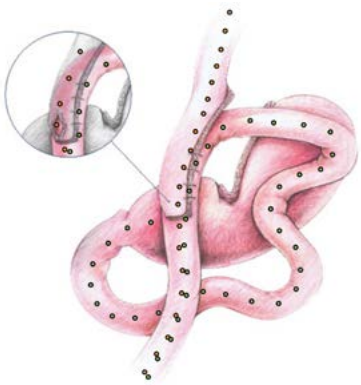
Assoc Prof Harald Puhalla, MD FRACS

by Harald Puhalla

In Australia more than one million people are diagnosed with type 2 diabetes and at least two million have pre diabetes.

The rapid increase of type 2 diabetes goes in hand with the well-known obesity epidemic. A strong association in-between increased body fat and insulin resistance was initially described as part of the Syndrome X in the 1980's. More recently in conjunction with hypertension and hyperlipidaemia, obesity and elevated glucose level were named metabolic syndrome. 80% of patients with type 2 diabetes are obese or overweight. When their diabetes becomes clinically apparent the risk for cardiovascular events rises sharply. In these patients obesity additionally increases their possibility of developing pulmonary embolism, cancer, osteoarthritis, depression or asthma.

The current management strategies of type 2 diabetes involves exercising, dieting, oral medication and/or insulin, but frequently the disease is slowly progressing and causes damage to a variety of organ systems. For decades researchers have tried to improve the treatment for type 2 diabetes and aimed to find a cure.



Omega loop gastric bypass: The postoperative food pathway is indicated as red dots and the pathway of the digestive juices (from pancreas, biliary and remnant stomach) are shown as green dots.

The gut hormones

Over the last few years it has become increasingly evident that the gastrointestinal tract plays an important role in energy regulation, and that gut hormones are involved in regulating the sugar metabolism. The gut hormones which significantly influence the glucose levels are GLP 1 (glucagon-like peptide-1), PYY (peptide YY) and grehlin. GLP-1 increases not only the insulin release in the pancreatic ß cells but also the sensitivity of the insulin receptors. PYY induces glycaemic control by early satiety and slowed down mouth to caecum transit time. Grehlin is also called the "hunger hormone" and if levels are low, appetite is decreased which reduces the urge to eat, therefore oral intake is small.

Bariatric operations can alter gut hormone expression

In a number of bariatric operations the bowel's anatomy gets changed. This leads to the gut hormone levels being expressed differently and has a therapeutic effect on abnormal blood sugar levels. Depending on the specific type of bariatric procedure performed, surgery can lead to short and long term effects on Type 2 diabetes.

Some bariatric operations treat diabetes only as an effect of reducing the calorie intake by creating a small gastric pouch (gastric banding) which has shown to improve blood sugar levels. However the long-term results in maintaining the weight loss and glycaemic control were less convincing.

A gastric sleeve or gastric bypass achieve better long term results by not only having a small gastric pouch, but also activating the gut hormones much more effectively. A sleeve gastrectomy is where the greater curve of the stomach is removed. This leaves only 20% of the stomach as a narrow tube in-between the oesophagus and duodenum. A significant postoperative reduction in the hunger-hormone ghrelin occurs and this shows better long term results in regards to diabetes and weight loss compared to the laparoscopic gastric banding.

The procedure which showed even better long term results to cure type 2 diabetes is a gastric bypass, where a small gastric pouch (calorie restriction) is combined with a bypass of the proximal small bowel. This surgical concept has the advantage of additional nutritional malabsorption and further induces a strong gut hormonal response.

Different bypass procedures have been used to date. The Roux-en-Y gastric bypass has been around in different variations and is certainly a good operation. But performing it laparoscopically is demanding since it requires two gut-to-gut anastomosis. This complex surgery can lead to long operating times and higher complication rates. More recently the omega loop gastric bypass (also called mini-gastric-bypass or single anastomosis gastric bypass) has gained significant popularity due to its excellent outcomes combined with a much less sophisticated surgical technique resulting in a low complication rate.

The omega loop gastric bypass

The omega loop gastric bypass has a long narrow gastric pouch, which is connected to the jejunum and bypasses the proximal two meters of the small bowel.

After this operation, the oral intake (red dots) passes

cont on P 18

A gut feeling

cont from p17

through the small gastric pouch and the anastomosis and enters the small bowel where the food mixes with the digestive juices from the pancreas, bile system and remnant stomach (green dots). Two important effects have been achieved: Firstly, the absorptive length of the small bowel is shortened. This causes a gentle malabsorption effect, adding an additional tool to losing weight in combination with the small gastric pouch. The second effect is the up-regulation of the hormones GLP1 and PYY caused by the distal entry of the nutrients into the small bowel. It is also presumed that the bypassed remnant stomach releases less of the hunger-hormone ghrelin.

Long term analysis shows that the omega loop gastric bypass is able to maintain excellent glycaemic control even beyond five years of the operation. The chance to remain off insulin is very high and only 16% require oral treatment. In comparison, patients five years after a sleeve gastrectomy, 62% are on oral diabetes medication and 8% require insulin. It has been shown that the gastric sleeve can be slowly "trained up" by ongoing or re-establishing wrong eating-habits (chronic over eating). Over the years the sleeve slowly dilates, the patient starts gaining weight and insulin resistance reoccurs.

An omega loop bypass is very effective in hyperglycaemia and established type 2 diabetes and also addresses obesity related comorbidities. Hypertension, hyperlipidaemia and sleep apnoea resolve in 90% of patients and osteoarthritis in more than 70%. This procedure may also help patients who have had poor results after a gastric band or sleeve gastrectomy to re-establish weight loss in the long term.

Some concerns have been raised that the malabsorptive component of a gastric bypass can cause vitamin or micro-nutrients deficiencies. All patients undergoing bariatric surgery should be investigated for pre-existing nutritional deficiencies before their procedure. This allows them to be treated in a timely manner. During the operation the length of the remaining "absorbing" small bowel in between anastomosis and caecum should be measured and be at least 3.5 meters. Daily multivitamin tablets after surgery help to prevent deficiencies. Further, a holistic treatment approach involving an experienced dietitian and a psychologist in the evaluation and postoperative management has shown superior long term outcome. However, patients should also be encouraged for a regular follow up with their GP or specialist where issues can be addressed early. Symptomatic deficiencies after an omega loop bypass are very rare and if necessary the operation can be reversed leaving a normal stomach and bowel anatomy.

The omega loop gastric bypass is an interesting treatment option for surgically fit people to cure their type 2 diabetes. Especially with its ability to activate specific gut hormones without relying only on a restricted oral intake, and in combination with a low complication rate. In conjunction with the resolving obesity related comorbidities this operation is able to maintain a good and healthy quality of life in the long term.

Genesis CancerCare demonstrates success with SABR program

Lung cancer is the leading cause of cancer death in Australia. Non-Small Cell Lung Cancer (NSCLC) is the commonest form, accounting for about 80% of all lung cancers. Surgery remains the gold standard treatment for early (stage I & II) NSCLC but only a small proportion of NSCLC patients are diagnosed in early stages. A significant number of these patients have cardiovascular and respiratory comorbidities and are therefore not suitable for surgery. Historically these patients were either treated with standard conventional radiotherapy or offered no treatment at all. However the outcomes after standard radiotherapy have been poor to modest (5 year survivals ranging from 0-42% with local control rates of up to 60%). Conventional radiotherapy is usually given over a 4-6 week period (20-30 visits) on a daily basis.

Matt Kelly and Joy Gu preparing to administer Stereotactic Ablative Body Radiotherapy

Stereotactic Ablative Body Radiotherapy (SABR), also known as stereotactic body radiotherapy (SBRT), is a relatively new technique, for treating small volume early stage NSCLC and small volume lung secondaries.

It is a complex and highly precise treatment that utilises specialised equipment to evaluate and account for tumour motion prior to and during radiation delivery.

Small lung tumours tend to move with respiration and this can be assessed using a 4D CT scan (time is the 4th dimension). A 4D CT scan during treatment planning ensures that the entire tumour pathway during respiration is mapped so that the tumour can be targeted with precision. Radiation planning for SABR is different to conventional radiotherapy and is done in such a way that there is less radiation dose spillage into the normal tissues surrounding the tumour.

Genesis CancerCare Queensland has installed modern 4D CT scanners on the Gold Coast (John Flynn Hospital and Premion place, Southport) as well a new state of the art Truebeam Linear Accelerator. The Truebeam Linac provides significantly faster radiation treatment when compared to conventional Linacs (approx 50% quicker) and permits conebeam CT imaging of a tumour for administering highly accurate radiation therapy.

In summary the potential advantages of SABR over conventional treatment include better local control (around 90%), fewer hospital visits (only 3-5 sessions over a two week period) and fewer side effects from the treatment.

For more information about Genesis CancerCare Queensland's SABR program please call 07 5507 3600 or email **sagar.ramani@genesiscare.com.au**

New neurosurgical service in Lismore

Dr Ananthanababu Pattavilakom Sadasivan ("Dr Babu") is an experienced Australasian Fellowship qualified neurosurgeon. After his initial medical training in India he spent ten years working in neurosurgical centres around Australia including Monash in Melbourne and Nepean Hospital in Sydney, as well as teaching at Sydney University.

More recently he has completed a spine surgery fellowship at Princess Alexandra Hospital in Brisbane. Dr Babu also holds a pain management fellowship, FFPMANZCA, from the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

Dr Babu is a general neurosurgeon treating conditions of the brain and spine. He has a particular interest in the neurosurgical management of epilepsy and neuro-oncology. Dr Babu works as a specialist at Princess Alexandra Hospital, Greenslopes Private Hospital and the Mater Hospital in Brisbane. He is a senior lecturer in neurosurgery at the University of Queensland.

Dr Babu has commenced consulting at Goonellabah Medical Centre twice monthly on Saturdays. Appointments can be made on 02 6625 0000.

BRAIN AND SPINE SURGERY PAIN PHYSICIAN

Dr Ananthanababu Pattavilakom Sadasivan ("Dr Babu")

Art Magic: Remnant - Artist, Hiromi Tango

Hiromi Tango, Art Magic: Remnant, photograph Natsky

Lismore Regional Gallery is presenting an exhibition and community engagement project with acclaimed Australian artist, Hiromi Tango.

Tango is a sculptural installation and performance artist who uses textiles to weave together tactile and immersive environments by hand.

by Kezia Geddes

For Art Magic: Remnant, her project and exhibition at Lismore Regional Gallery (exhibition 12 September to 26 October 2015), Tango has been working with local community members to make a Rainbow Forest, responding to the flora, fauna and landscape of the Lismore region.

Tango has used the concept of the regeneration of the rainforest as a metaphor for emotional healing. She has a strong belief in the therapeutic qualities of her process and has developed "Art Magic recipes" to share the delight of making. Tango has worked extensively with a variety of community groups including local artists, the elderly, anxiety sufferers, children and young people, students, people living with a disability and culturally diverse community members.

Kezia Geddes is the Curator of Lismore Regional Gallery.

Push for Lismore creative precinct gathers pace

by Brett Adlington

Artist's impression of the western view of the proposed Lismore Regional Galley

Lismore City Council recently submitted an application to the National Stronger Regions Fund to relocate Lismore Regional Gallery, currently in Molesworth Street, to the 'Lismore Quadrangle', located on the old Lismore High School site, in the Keen Street block.

The project will include the redevelopment of the existing C-Block building to contain Lismore Regional Gallery, Arts Northern Rivers (currently located in Alstonville) and the Co-op Bookshop (currently located in Woodlark St). The grounds between C-Block, Northern Rivers Conservatorium and the Lismore branch of the Richmond Tweed Regional Library, will be landscaped to connect all these organisations to create the 'Quadrangle'.

'Economic Growth' and 'Addressing Disadvantage' were two key criteria addressed in the application.

'The Arts' can speak to these very clearly. It's long been known the economic impact that culture has on cities and towns – just look to Spain's Bilbao, and in Australia Hobart and Bendigo, and more recently Murwillumbah, home of the superb Tweed Regional Gallery and Margaret Olley Arts Centre, to see the singular effect of cultural infrastructure.

A report commissioned by Lismore Regional Gallery shows that the expansion of the Gallery will bring an economic benefit of over $4 million annually to Lismore through increased visitation.

What is harder to measure, but equally as transformative, is the social impact the arts play in people's lives. This leads to the second criterion. Lismore Regional Gallery has an established reputation working with a range of community organisations to ensure the arts play a positive role in people's lives.

Currently the Gallery is working on a number of projects with a range of groups, including Bundjalung and Gumbaynggirr artists, to create new work based on cultural objects; R.E.D Inc, Jarjum Aboriginal Pre☐ school, Fromelles Aged Care Facility, and artists from the Deaf community of Lismore are all working on the Hiromi Tango project.

We have also partnered with Youth Connections for young people to learn photographic skills and to be displayed in the Gallery, and a 2014/15 project, working with artists with a Disability, which is currently being reworked for display at Wagga Wagga Art Gallery.

All these projects offer different ways of engagement for a range of groups, building skills, connections, resilience and confidence.

The National Arts and Health Framework, developed by state and territory arts and health ministers, identifies that "arts and health activities have intrinsic, instrumental and institutional values and have a demonstrated range of social, artistic, environmental, cultural, economic and health benefits, including the potential to improve the quality of health care".

An expanded gallery, with 230% increase in exhibition spaces, and provision of climate control facilities, will mean a greater range of exhibitions are able to be scheduled, with the ability to display works on loan from major institutions. Coupled with dedicated workshop space to better facilitate a range of projects and art making, this means not only an increase in visitor numbers, as evidenced in all gallery expansions, but much stronger creative engagement with all facets of the community.

Brett Adlington is the Director of Lismore Regional Gallery and President, Regional & Public Galleries Association NSW.

Practice update...

People caring for people

DR GENEVIEVE BISHOP

BSc (Hons psych) MBBS MPH FRANZCO

Obstetrician & Gynaecologist

Special interest in Uro-Gynaecology and Incontinence

NEW FEMALE O&G

Dr Genevieve Bishop

Commencing October 2015

at John Flynn Private Hospital

Dr Genevieve Bishop is an obstetrician and gynaecologist with a particular interest in incontinence in both the young and older female population.

She studied at Sydney University attaining a Bachelor of Science with Honours in Psychology. She then continued her studies also attaining her Bachelor of Medicine Bachelor of Surgery from Sydney University. During her training she also attained a Masters in Public Health from the University of NSW.

She trained at obstetrics and general gynaecology at Royal Prince Alfred Hospital in Sydney and pursued her interest in uro-gynaecology and incontinence with a specialist year at St George Hospital working in the internationally renowned Pelvic Floor Unit.
During her training she also spent over a year at The Tweed Hospital and is familiar with the varied needs and wishes of the community in their approach to care.

Dr Bishop believes in a women centred approach for lifelong care. Her primary outcome in obstetrics is for a safe pregnancy for mother and baby however she realises there are many ways to achieve this.
She understands that birth is not only about making babies but making mothers strong, competent and capable, and who trust themselves and believe in their inner strength.

Her particular interest in continence acknowledges the devastating affect it can have on a woman's life no matter how big or small an issue it may be. She strives to treat her patients with appropriate management both medically and surgically to help them achieve an optimal and fulfilling life. She will be offering Urodynamics to assist other clinicians in their ongoing patient care as well as to aid in management of her own patients.

Contact details:

John Flynn Private Hospital
The Women's Health Centre
Suite 8B, Level 8, Fred McKay House
John Flynn Private Hospital, 42 Inland Drive
Tugun, QLD, 4224
Phone : 07 5598 0202 **Fax :** 07 5598 0201
www.thewomenshealthcentre.com

JOHN FLYNN PRIVATE HOSPITAL

PHN with Data

by Dean Denman

Improved data management through clean data will make looking after patients easier for both GPs and their medical practices, as Dean Denman explains.

The new Primary Health Networks (PHNs) will have an increased role in supporting practices undertaking chronic disease management. Under the new arrangements there will be a greater focus on data analysis at the practice level. In the past many practices, particularly those that have taken part in federally funded quality improvement programs, have used clinical audit tools such as PENCAT and Canning. Many of the contracts for using these tools have now expired and other options are being explored.

Nearly all clinical software has built in tools to extract data useful for the management of chronic diseases.

Medical Director (MD) and Best Practice (BP) are the two most commonly used electronic health record systems in Australia. Both companies have support teams with experience in running queries and they are a great resource to get your practice started in identifying and managing your chronic disease patients. Your PHN's practice support teams should also be able to provide guidance on database interrogation.

"Garbage in, garbage out" is an information technology maxim. Clean data is a requirement for useful analysis. BP and MD both have tools to simplify the process and "scrub up" your data.

The two main tasks are inactivating old patients and coding "free text" diagnoses.

An up to date list of patients allows you to concentrate efforts on useful activities. It is also an accreditation standard.

Coding all diagnoses is the first step in preventing patients missing out on possibly useful interventions. It is also an eHealth Practice Incentive Payments requirement

Best Practice

Inactivating patients is a simple process in BP. With the built in Search Tool set the "From Date" to two years ago, tick the NOT option and click Add and OK. The search returns those patients who have not been seen for two years. To remove these patients from your active list use the "Mark as Inactive" option in the File menu.

Dean Denman

Coding diagnoses is also a simple matter but laborious depending on how many diagnoses have not been previously coded. The BP Utilities program has a "Clean up History" tool that allows users to work through the list of uncoded diagnoses and assign them codes. When opened this tool presents two lists – the left hand panel has uncoded diagnoses and the right a search list for the coded diagnosis that could be used. A "Replace" button makes the change.

Medical Director

Inactivating patients in MD is similar to BP. The built in search tool is accessible from the main screen. Select the "Patient" option and set "Not seen since" to two years ago. Click Search and use the "Inactivate Patients" option.

Diagnoses are coded through the HCN Maintenance suite. The Diagnosis Coder tool is in the Medical Director section. Select the uncoded diagnosis on the left and the coded diagnosis on the right to perform the coding.

Coding Policy

The coding diagnoses procedure above is a one off process. If free text diagnoses are allowed the data will become unsearchable once again. To prevent this the practice should have a data entry policy which stipulates that all diagnoses, where available, should be using the coding option supplied by the program. This is available via a drop down box in most programs.

Querying for patients at risk of, diagnosed with, or receiving treatment for - or none of the above and combinations of any of these - can be done with confidence once you have clean data

Useful and commonly used queries can be provided by your software's support teams. Many vendors will also assist with custom queries. However, when requesting these, be clear and accurate in what you want. A minor change in query syntax can make a dramatic difference to the list that is returned.

If using the analyses for chronic disease management, practices need to aware of the ramifications.

- Data cleansing is time consuming. You will need to allocate sufficient staff time.
- Staff members have to be vigilant about the data they are entering (encourage a little OCD in your doctors!).
- Your database queries may not give you the information you want. If you are unsure, your PHN's Practice Support Officers may be able to assist.
- Clean data maintenance requires regular

cont on p24

PHN data

cont from p23

administrative activity over and above normal patient consultation time.

- Poor data can compromise patient care.
- The practice is accountable for the data being used.

Once you have made these commitments you can reap the benefits.

- Data quality improves and is maintained and can lead to better care.
- There is no requirement for installation of third party software or for data sharing agreements with external parties.
- It is internal to the program so you have direct access to the patient record. No need to swap between programs to get access to additional information on a particular patient.
- It is customisable. Queries can be easily tailored to the practice's own requirements.
- Generating reminders or recalls is simple once a list of patients in returned by a query. (e.g. Diabetics due for a HBA1c, asthmatics without a spirometry performed in the last year.)
- Patients do not fall through the cracks and your patient population is generally better managed.
- Data is kept inside the practice. Privacy is maintained.
- Clean data serves as a good starting point and is a precursor to more comprehensive chronic disease management through clinical audit tools.

Australia's population is ageing and complex and chronic disease is becoming more common. Improved data management through clean data will make looking after patients easier for both GPs and their medical practices.

Dean Denman worked at Best Practice Software support for seven years where he had a keen interest in data analysis for better patient care. Earlier this year he moved to the Sunshine Coast Medicare Local (now PHN Country to Coast) where he is working on meaningful use of data in practice software in their chronic disease management programs.

Let's drink to that

by Aaron Bertram

Actor Aaron Bertram reflects on his immersion in Sydney's drinking culture.

Lest you were in any doubt that booze is as much the lubricant of Sydney's arts and entertainment scene as ever it was, you can sweep any lingering doubts away.

Some of you may be aware of a recently released feature film called Ruben Guthrie. Many more of you, of course, will not. It's Australian, after all.

Written and directed by Brendan Cowell, starring Pat Brammall as the titular character, and featuring me in a small but pivotal role (as we say in the business), Ruben Guthrie tells the story of a high-functioning alcoholic adman who is forced by physical injury into a moment of clarity – and by love into a year off the sauce.

The script, an adaptation of Brendan's wildly successful play, is a postcard for Sydney's luxuriant drinking culture, as well a cautionary tale of the grinding dullness and inconvenience of sobriety.

Yes, we know it's bad for us. The liver strains, the brain protests, but the heart wants what the heart wants, and what the heart wants is more.

And, in Australia, drinking is how we show we have one.

In this country, you can't trust someone who doesn't drink. The assumption is they have a drinking problem. A strange assumption when you think about it.

Actor (and former GP Speak editor) Aaron Bertram with former university mate Brendan Cowell, director of Ruben Guthrie, and Jack Thompson, one of the leading cast members.

Ruben Guthrie is really about how hard it is for Australians when someone they love puts the bottle down without a court order.

A close friend of mine recently wanted to have a bit of a break from booze. I was devastated. Our friendship had been formed in the froth of balcony binge drinking. What would we do now?

For Ruben, it meant his job was on the line, he was forced to befriend earnest passive aggressives, and be all but disowned by his parents.

In a case of life not imitating art or, more accurately, life rolling on regardless, my engagement with the material by no means inspired any clear moments in me.

I'm neither proud nor ashamed to say that during the celebratory whirl of premieres, parties, after parties and after after parties, honestly, I've never been so pissed in my life.

And if you're wondering why I'm revealing to you all, especially as doctors, my cavalier disregard for both the theme of the film and the concerns of the health system, the answer is, well, the editor offered me a bottle of wine.

And I have nothing more insightful to say than, "Cheers, Robin!"

***Aaron Bertram** is a Lismore-based writer and a former editor of GP Speak. An accomplished actor, he played the role of Ken, a member of AA who befriends alcoholic ad man Ruben Guthrie in the Australian film of the same name.*

Film Review - Ruben Guthrie

by Robin Osborne

Ruben Guthrie, a notable on-stage success, is one of four plays to become Australian films this year, not always an easy transition, although settings like Bondi and Randwick racecourse seem central to this quintessentially Sydney flick.

The man of the title is an acclaimed, hard partying advertising creative who comes to grief when he jumps off a balcony during an alcohol fuelled party at his glamorous lower North Shore house.

While his swimming pool helps cushion his fall, his Czech model fiancée Zoya (Abbey Lee), decides not to, and roundly damns Australia's drinking culture before storming back home. The only way she may reconsider the split is if Ruben (Patrick Brammall, seen recently in the ABC series Glitch) can give up the grog for a year.

So begins a round of AA meetings, equally awkward confrontations with Ruben's well lubricated friends, and a predictable tumble off the wagon that becomes a descent into hell.

The script is tight, and Brammall's performance excellent, at times reminding me of those marvelous declamations by DiCaprio in The Wolf of Wall Street.

The film's happy-ish ending should not be revealed. More important is the cringe-making journey to get there, one that says much about the role of alcohol in our national life, and not just on the screen, as actor Aaron Bertram outlines in his companion article.

Down on the mat

by Robin Osborne

In the Northern Rivers, there is no shortage of yoga options, from the traditional to the upside-down. GP Speak editor and yoga enthusiast Robin Osborne investigates this increasingly popular form of exercise.

Cricket may be India's national sport but it is the home-grown pastime of yoga that has been enshrined in the governance of the country where it was developed. After coming to office a year ago, India's charismatic prime minister **Narendra Modi** established a ministry with a name as complex as a difficult yoga asana (posture) – the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy.

Then, with the backing of the UN General Assembly, he announced that an International Yoga Day would be held annually on June 21, the solstice/equinox, depending on the hemisphere one inhabits.

The meaning of the Sanskrit word 'yoga' is to 'yoke' together, or unify, the body and mind. One wonders how Modi's sentiments resonate with the lycra-clad practitioners who flock to studios in the west, not least Byron Bay, which hosts yoga schools of every imaginable kind.

While the exact number of adherents in Australia is not known, up to a million may be doing yoga each week, and the figure is growing exponentially.

Perhaps more interesting is who is doing yoga, who isn't, and why not?

The first question is easy to answer – visiting any studio reveals that yoga is not a man's world, even if all the well-known teachers have been (Indian) men.

The other questions are more complex. Given the lack of men in classes, yoga is not viewed by males as being 'tough enough', although it's a lot tougher than sitting on the couch, operating the TV remote.

A national survey found that

GPSpeak Editor comes to grips with an aerial yoga class.

85 per cent of Australians doing yoga were women with a typical practitioner being a 41-year-old, tertiary educated, employed, health-conscious female.

Respondents said they often started practicing yoga for health and fitness but continued practicing for stress management, with 1-in-5 doing yoga for a specific health or medical reason which was seen to be improved by yoga practice.

Of these, more people used yoga for stress management and anxiety than back, neck or shoulder problems, suggesting that mental health may be the primary health-related motivation for practicing yoga.

One thing is certain: yoga is not a cardio workout, although the more vigorous styles such as Ashtanga and Power yoga can get the blood pumping, and beyond those there is Pilates, which incorporates yogic flexibility exercises with a fast moving routine – and often more men in attendance.

On the subject of styles, the choices seem almost infinite, mostly grouped under the general term of Hatha yoga, which is the predominantly physical form. They include Raja, Kriya, Ananda, Svaroopa, Sivananda, suspended Aerial yoga, and two styles named after their founders - Iyengar yoga, a precise style formulated by the legendary yogi BKS Iyengar, and immensely popular worldwide, and Bikram yoga, developed by a Rolls Royce driving, alleged sexual predator, Bikram Choudhury, first brought to the USA by the American Medical Association.

Does yoga work?

Unlike, say, fish oil capsules whose benefits seem subtle at best, the regular pursuit of yoga does result in discernible improvement in flexibility, balance and the ability to relax, as well as, in many cases, physical strengthening and weight loss.

At least, this is my experience, having taken it up in 1970 while living in Hong Kong.

My un-guru like teacher was a humble man named Mr Wong whose tiny ad in the local paper, headed simply 'Learn Yoga', gained the attention of a group of dissolute Aussie expats. This was something we could do at home, apart from boozing, although as soon as the lithe Mr Wong was out the door we would be pouring gin-and-tonics, and saying how good we felt.

Yet we kept at it, and I have no doubt that yoga has delivered me priceless health benefits, although I'm keeping up the long, early morning walks.

eDLs make GPs say WTF about SNTs, etc

While regarded as an essential means of communication between hospitals and GPs to facilitate optimal care of patients returning to the community, electronic hospital discharge letters, or eDLs, are insufficiently understood by doctors, and this is putting patient wellbeing at risk.

This is the key result of a major survey of GPs in Sydney's Nepean Blue Mountains area, and the findings are likely to apply elsewhere.

The 2012 survey, details of which were published recently in the Medical Journal of Australia was based on an audit of 321 identified abbreviations used at Nepean Hospital.

From these, the 15 most commonly used, as well as five clinically important abbreviations, were selected.

Around 55 per cent of the 240 GPs contacted by mail chose to respond. The results included the finding that no single abbreviation was correctly interpreted by all the participating GPs, while six abbreviations were misinterpreted by more than a quarter of GPs.

These were SNT (soft non-tender, interpreted incorrectly by 47 per cent), TTE (transthoracic echocardiogram), EST (exercise stress test), NKDA (no known drug allergies), CTPA (computed tomography pulmonary angiogram), and ORIF (open reduction and internal fixation).

The researchers concluded that abbreviations used in eDLs are not well understood by GPs receiving them and "this has the potential to adversely affect patient care in the transition from hospital to community care...

"Worryingly, more than half of the abbreviations we found related to investigations, management or services that we considered to be the most clinically significant categories.

"Misinterpretation of abbreviations by GPs can adversely affect patient care through duplication of investigations, failing to institute treatment based on investigation results or failing to follow up with recommended management."

They said potential solutions included banning the use of abbreviations or using only a limited number of hospital-approved abbreviations and providing GPs with an approved abbreviation list.

They cited reports that abbreviation use is increasing and identified this as a concern. A recent audit at Royal Melbourne Hospital reported that 20.1 per cent of all words in discharge letters were abbreviations.

One study audited abbreviation use in inpatient medical records and surveyed members of an inpatient multidisciplinary team for their understanding of abbreviations.

Alphabet Soup image courtesy of **revbean** *(CC BY-NC 2.0)*

"Another option would be use of computer software to auto-complete mutually exclusive abbreviations (ie, allowing only one possible meaning for each)," they added.

They explained that abbreviations used in medical communications are either acronyms or initialisms.

"Acronyms use the initial letters of words and are pronounced as words (eg, ASCII, NASA); initialisms use initial letters pronounced separately (eg, BBC). Abbreviations are commonly used in medical specialties, but may not be understood by the broader profession. Doctors are under pressure to complete discharge letters in a timely fashion, and abbreviations may be used to facilitate this process."

The mean correct response rate was 43 per cent, with Postgraduate Year 1 doctors posting the best scores (57 per cent) and dietitians posting the worst (20 per cent).

"However, we identified no published studies determining whether the abbreviations used in hospital discharge letters are understood by GPs, who are usually the recipients of discharge letters.

General practitioner understanding of abbreviations used in hospital discharge letters Med J Aust 2015; 203 (3): 147. Mark Chemali, Emily J Hibbert, Adrian Sheen, Mark Chemali, Emily J Hibbert and Adrian Sheen