GP*Speak*

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Meet the man of the Moon

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GPSpeak

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PO Box 106, Lismore, NSW 2480
Ph: 0266 273300 Fax: 0266 223185
editor@nrgpn.org.au ● www.gpspeak.org.au

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The October 2014 lunar eclipse photographed from Lennox Head by Dr Stephen Moore.

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Editorial

Image: Respect - CC BY-SA 3.0 Nick Youngson Alpha Stock Images

Sexual harassment, now being widely reported in various occupational fields, has also been receiving increased attention in recent years in medicine. Melbourne vascular surgeon, Dr Gabrielle McMullin, controversially put the subject on the agenda when she **said**:

"What I tell my trainees is that, if you are approached for sex, probably the safest thing to do in terms of your career is to comply with the request. The worst thing you could possibly do is to complain to the supervising body, because then, as in Caroline's position, you can be sure that you will never be appointed to a major public hospital."

The quote may be apocryphal, or said through clenched teeth or even tongue in cheek, but sadly it rang true - Dr McMullin's cri de coeur was damning about the state of affairs in medicine, and distressingly similar to the situation in the movie industry, and elsewhere.

To focus the discussion, she has contributed the medical chapter to the book, **Pathways to Gender Equality in Australia.** She covers the history of women in medicine and their continuing low representation in some disciplines such as surgery. She recounts the American experience where surgical departments were often hostile environments for women until they reached a tipping point of 40 per cent women. She concludes by noting that:

"History shows that it is women themselves who create these changes and strong networks are required to ensure that women are properly valued and clearly seen and heard."

The surgical department of Lismore Base Hospital has reached the tipping point in that their female percentage is over 40 per cent.

Reflecting recent social changes this year two new doctors' groups have formed on the North Coast. "Women in Medicine" and "Men in Medicine" aim to foster connections, friendships and mentorships to support colleagues over the course of their careers.

The groups, in conjunction with Lismore Base Hospital and the North Coast Primary Health Network sponsored a welcome dinner for the new interns in late January. The initial gathering was considered a great success and further events are planned.

In a similar vein, North Coast haematologist Dr Louise Imlay-Gillespie, has established the **Northern Rivers Doctors Facebook Group**. On page 9, she describes the aims of the group and its plans for the future. Adding Facebook as an electronic means to communicate about general North Coast health matters builds on previous work she had done in organising an annual week-end retreat for North Coast specialists. The current membership of NoRDocs is nudging 100.

In this issue Dr Jane Barker brings us the latest revision to the World Medical Association's Declaration of Geneva, Physician's Pledge. Respect for oneself, one's colleagues, one's patient and human life are the essential elements.

December 2017 saw the release of the final report of National Forum on Reducing Risk of Suicide in the Medical Profession (page 14). Once again the dominant themes are changing the culture of medicine and looking after one's own health. These are tasks that only doctors can do for themselves. Following the forum a national Patron's group is forming this year to progress the recommendations of the report.

Changing a community is difficult. A somewhat unlikely model of success in promoting gender equality, diversity and inclusion is the Australian Linux community. Each year a bunch of computer nerds come together to meet and speak about their passion. The community is diverse, ranging from school kids to some of the smartest technologists on the planet. By applying their minds to the task they have made significant changes in recent years.

Medical cannabis has been available through a Special Access Scheme for 12 months but at most a few hundred prescriptions have been dispensed so far. On page 25 we report on the business enthusiasm for establishing a commercial glasshouse operation near Casino. Many Australian GPs remain sceptical of the extensive therapeutic claims for the drug and await the experience of California where **marijuana** became widely available from 1 January 2018 for both therapeutic and recreational use.

March 2018 marks the 25th year of the Northern Rivers General Practice Network. On page 23, Dr Andrew Binns, looks back over the years and pays tribute to all the previous editors. GPSpeak has raised and reported on a host of local medical issues in that time and we intend to continue to do so for the foreseeable future.

I thank our readership and editorial team for their contributions over these years and I send them my respect.

Former local GP honoured in Qld

by Andrew Binns

Well known GP Kingsley Pearson *(pictured holding award certificate)*, formerly residing in the Northern Rivers, has been honoured as North Queensland GP of the Year. The award was made by the North Queensland Primary Health Network at a ceremony held at Gurriny and attended by all staff, the Elders of the community and other community members, and the CEO and Chairperson of the Board of the PHN.

"I feel very lucky that I have been able to work in the arena of indigenous health for the past 11 years," Kingsley told GP Speak.

"It has not only taken me to some remote and beautiful locations around Australia, but it has introduced me to a whole new group of people, strong in culture, and amazing in spirit, who have huge and complex health needs, that deserve our attention and involvement."

Kingsley came to Nimbin as a GP in the early 1980s and was there for more than 12 years before setting up the Prema House general practice in Lismore.

In 2007 he started working for Katherine West Health Service at Lajamanu in the Northern Territory. He worked on Elcho Island for two years and then at Yarrabah near Cairns in 2010. This was interspersed with work in the Solomon Islands and the NT.

At Yarrabah he initiated a Chronic Disease Program. In 2012, he took on the role of Senior Medical Officer for the Gurriny Yealamucka [Good Healing] Aboriginal Health Service, and was part of the senior management team that enabled Gurriny to transition to a community controlled health service in 2014.

Last year he did some relief work at Jullums Lismore Aboriginal Medical Service, which has now transitioned to an Aboriginal-controlled health service under **the management of Rekindling the Spirit**.

We congratulate Kingsley on this richly deserved recognition of his dedication and professionalism.

Image by photographer Christine Howes

UCRH seeking student placements

The University Centre for Rural Health North Coast wants more local GP practices to become involved with providing placements for long-term medical students attached to UCRH for this university year.

"We are looking for more practices and more commitment to undergraduate teaching," education coordinator Dr Jane Barker said.

Placement programs of varying lengths are offered by three universities, Sydney, Western Sydney and Wollongong.

"A majority of medical students will become GPs and we want them to embrace general practice with enthusiasm as a specialty in itself," Dr Barker said.

"Those who do not become GPs need a comprehensive and realistic understanding of the breadth of General Practice... which offers the student a wider, holistic perspective on health - continuity of care, of patient centred care, preventative care, care across ages, care across medical disciplines."

Dr Barker stressed the importance of "succession planning" as many students return to join the GP training program and stay on as GPs in the area.

"Alternatively they are choosing rural general practice in other areas, thus increasing the rural workforce," she added.

Details from Dr Jane Barker, UCRH, email Jane.Barker@ucrh.edu.au or phone (02) 66207570

UNIVERSITY CENTRE FOR RURAL HEALTH NORTH COAST

Winter is Coming - Again

by Dr David Guest

Image: 'French retreat from Russia in 1812' by Illarion Pryanishnikov (1840-1894) Copyright Public Domain

As previously noted in these pages a **Winter Strategy** is a wise precaution for invaders of Russia and health bureaucrats alike.

2017 was the first year of a joint project between the Northern NSW Local Health District and the North Coast Primary Health Network aimed at reducing the number of admissions to hospital over the winter for patients with preventable disease, particularly with the complications of influenza infection.

The **strategy** involved **improving flu vaccination rates** in the elderly and improving communication with hospitals, both on admission and discharge. However, the main component of the project was resourcing general practices to take a more active role in managing their sicker patients.

There were three components to improving GP care. Firstly, all these patients had a shared health summary that was readily available to other health practitioners. The electronic My Health Record was the favoured option. However, it is new technology with some early implementation problems that made it difficult for many practices to use and virtually impossible for all elderly patients. Previously practices on the North Coast had found a paper-based, patient-held record the most functional format for communicating clinical information.

The second component was for each patient to have a chronic disease management plan. Care planning has matured over the 12 years since it was first introduced in 2005 and many patients already have these in place.

The third, and newer, component was to have a Same Day Action Plan. This document details what patients should do if their condition worsens. Plans for diabetes, heart failure, COPD and renal disease were developed and published on **HealthPathways**, the North Coast repository for local protocols and resources.

The 2017 Winter Strategy was developed and rolled out under a very tight time frame. It is a tribute to the co-ordinators and participants that significant inroads were made into "winter wellness" management. Many mistakes were made but much was learnt in the process.

Despite the problems encountered, all parties acknowledged that it takes several years to bed down changes in workflow and reporting when they involve multiple parts of the healthcare system.

Preparations for Winter 2018 started early, in December 2017, with an extensive debriefing of the previous year's participants. As a result of this feedback, the plan for the current year is to run the program as a mini collaborative.

Collaboratives are a change management tool familiar to many North Coast practices as a result of their previous involvement with the Improvement Foundation and the **North Coast Integrated Care Collaborative of 2015-2016**.

The structure provided by the collaborative process will be welcomed by participating practices in the Winter Strategy, with a clearer understanding of the goals, better communication between the practices and two workshops for practices to share the knowledge they have gained. In the jargon of the Collaboratives, they can "Share generously. Steal shamelessly."

With last year's experience behind them, it will not take practices long to organise their teams and to choose, recruit and monitor their high risk patients. They are now familiar with the tools and have the systems in place to follow their patient's status, catch deterioration at an early stage, and refer those patients to the hospital when that cannot be managed at home.

All this will continue in the 2018 strategy but the focus for the coming year is patient **self-efficacy**.

Thirty years ago Australian epidemiologist **Sir Michael Marmot** documented in British civil servants the positive correlation that higher rank had on health outcomes. While the exact mechanism is still debated, **some argue** that it is the ability to control one's environment that determines the outcomes.

Putting patient centred care into practice has been shown to be difficult for both GPs and specialists. We tend to focus on the numbers and the targets without ever exploring how the patient might get there, or even, if they think it is a worthwhile goal.

To assess patients' attitudes and personal health rating, they will complete two surveys, one at the start, and then again at the end of the program. These patient-reported experience and **outcome measures** both set the agenda for the individual patient and provide a framework for evaluating the Winter Strategy as a whole.

Clinicians will also be asked about their experiences of the program. Areas to be

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Winter is Coming - Again

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covered include whether the admission and discharge notification system worked well and improved care, whether there was better integration of the LHD's Chronic Disease Management team with the surgeries', and whether services external to the hospital, such as physiotherapy and exercise physiology, were utilised to good effect.

The experience of Winter Strategy 2017 suggested that patient selection had been appropriate. Analysis of the data showed that nearly a third of the enrolled patients had an unplanned hospital admission and a significant number of other patients had also attended Accident and Emergency. It has been suggested that for 2018 the hospital may undertake further analysis of unplanned admissions for patients not on the program but who may have benefited from inclusion.

It is also planned that some practices will measure the timeliness of automated admission and discharge notifications as well as discharge referrals. Improving these parameters should make patient care far more streamlined.

Despite its early teething problems the program has been judged a success by practices, with 92% of respondents stating they will take up the program this year.

Many practices are looking forward to engaging with their patients on the same-day action plans and ensuring that the patients understand their role in their care and feel confident in taking the next step in their plan if their condition starts to deteriorate.

Health coaching, motivational interviewing and fostering patient empowerment to implement their plan is an exciting new task for many practices and their Chronic Disease Management (CDM) teams.

Many participants are interested in continuing the program beyond 2018, depending on continuing funding. The cost for 2017 was relatively modest at $158,760 and if clinical benefit can be shown it would be foolish to stop.

One area that could be usefully looked at in the future is greater involvement with community pharmacy both within the practice and after hospital discharge.

Winter is coming but the supply chain has improved. Hopefully death and destruction can be kept to a minimum in this and future years.

Mandatory Notifiable Data Breaches

*Marco Ostini is the Principal Analyst at **Pandimensional Infosec** based in Brisbane. He has a particular interest in the information security of smaller medical practices. He can be reached on twitter @Pandimensional_.*

by Marco Ostini

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Medical practitioners or small business owners should have the date 22 February 2018 in their calendar, for that is when the **Notifiable Data Breaches (NDB) scheme** took effect throughout Australia.

What is it, who does it target, how should you prepare and why does it exist? Each of these questions will be answered in this article.

What is the NDB?

The NDB is new. Legislation has recently been passed amending the Australian Privacy Act to establish the scheme in Australia.

The scheme includes the obligation of an applicable entity, for example a medical practice, to notify people, who may include patients and staff whose personal information they hold, that have been involved in a data breach and, as a result, are at risk of suffering serious harm. The Australian Information Commissioner must also be notified of the breach.

An applicable entity that fails to comply with the new legislation could lead to responsible individuals, such as the practice principals or key employees, being issued penalties of up to $360,000. The entities themselves may face penalties up to $1.8 million.

Who is affected?

The **NDB scheme** applies to all Australian Government agencies, businesses and not-for-profit organisations with an annual turnover of $3.0 million or more and entities that provide any health services.

How will it function?

As ever, prevention is better than cure. You do not want to find yourself in front of a TV news camera attempting to answer awkward questions. And there are worse case scenarios!

To its credit the Office of the Australian Information Commissioner (OAIC) has prepared many excellent guides, including one to **developing a data breach response plan**. This guide is not optional for those wishing to avoid the consequences of a breach and should form part of the overall information security protocols for your practice.

A well prepared and well understood data breach response plan needs to be ready for action. It will save you time, confusion and anxiety. The preparation of the data breach response plan is made a lot easier with the guidance and cooperation of an Information Security professional. In most cases this will not be the same person or company who installs and maintains your computers.

To identify a breach you need to be looking for it. There are many potential ways for a breach to occur. Uninformed user actions, poorly maintained or designed systems and third party failures are some of the many potential causes. So engaging an Information Security professional is strongly recommended.

A suspected breach needs to be investigated promptly, and if identified, immediate steps should be undertaken to contain it. An assessment of the breach is required to determine if the stolen data is likely to result in serious harm.

For example, does the data include Medicare numbers, health care numbers, health information, driver's licence details, financial account numbers such as debit or credit card numbers, names and passwords or other sensitive personal information and is it, or was it ever, available in a public place unencrypted?

The investigation and assessment must be done "expeditiously", with the entire process completed within 30 days.

If a breach does include data that is likely to result in serious harm, then notifications to those impacted and the Australian Information Commissioner must be sent.

This handy **OAIC flow chart** describes the steps.

Why the scrutiny?

The NDB scheme encourages good privacy practice. It upholds the rights of individuals to determine how their personal information is used and managed. It has been made law as an extension of the Privacy Act. Misuse of stolen data has been an issue for some years

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Good health for data

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in Australia. It has taken Australian security experts 10 years to convince the government to implement changes that address at least some aspects of the problem.

Many breaches of personal data, including those of clients and staff of various large entities globally and in Australia, have already occurred and have done so for some time. This highly sensitive and highly personal data is systematically collected by cyber criminals who use it for breaking into systems, fraud, extortion and other illegal practices based on identity theft.

This data is very valuable to malicious entities who understand information technology and the internet far better than those who neglect their systems and suffer a breach. The NDB legislation seeks to reduce the flow of personal data to criminals who abuse it.

The NDB legislation, by way of its penalty scheme, provides a difficult to ignore indication of the high value of medical data. Practitioners are now required to meet a higher standard of personal information handling than they have in the past.

Help required

Medical professionals already have more than enough to do in staying current with contemporary medical research, technologies and techniques. Adding professional Information Security Analysis and Implementation skills to their daily work is too much to ask.

Doctors and practice managers understand that modern medical practice needs support from professionals in a variety of fields. Check with your legal professionals to confirm all your legal obligations under the Notifiable Data Breaches (NDB) scheme and get to know some Information Security professionals who can assist you to take the necessary measures to avoid a breach.

Put the measures in place to detect a breach and prepare your Incident Response Plan so that it is ready if a breach should occur.

Good health rarely happens by accident, nor does good Cyber health. Some pro-active steps today, along with good daily habits, will lead to a much happier and productive future.

Prevention is also better than prosecution.

References

1. **Data breach notification — A guide to handling personal information security breaches**

2. **Data breach requirements in the My Health Record system**

Marco Ostini

NoRDocs Facebook Group

Dr Louise Imlay-Gillespie is a haematologist in the Northern NSW Local Health District and is based at the Lismore Base Hospital. She is the founder of the Northern Rivers Doctors Facebook Group.

Dr Louise Imlay-Gillespie

In December 2017 the Northern Rivers Doctors (NoRDocs) Facebook Group was officially launched. This group was conceived by a mixed group including GPs and hospital specialists alike. Since initiation it has grown quickly and already boasts more than 90 members. Membership is confined to doctors, past and present, working or living on the North Coast.

The group is intended to provide a space for Medical Practitioners from the Northern Rivers to communicate, collaborate and advocate on medical issues affecting our community. It is hoped that this will encompass the whole of the Northern Rivers region from Grafton to Tweed Heads. This is an independent group that is not affiliated with any organisation or government department.

Any member can contribute any post that is relevant to our medical community including educational articles, reports of services offered and upcoming events or meetings. It is hoped that there will be 'champions' for each region and specialty that will ensure content remains timely and useful to members of the group.

Ultimately it is hoped that this platform will provide a springboard for our own events that will be run by Northern Rivers Doctors, for Northern Rivers Doctors. Indeed plans are already under way for a one day meeting later in the year that provide some key-note sessions as well as facilitating discussion through 'open' sessions where anyone can present on any medical topic of interest to our area.

This is a unique opportunity to break down barriers in medicine and work together to achieve optimal outcomes for health in our region. If anyone is interested in joining the group, they can contact me via email on louise.imlay@gmail.com or find me on Facebook (Louise Gormally).

Rural students discuss placements

An in-depth study of the lived experiences of students of health professions undertaking non-metropolitan placements has shown they rate highly the benefits of supportive staff and good interactions with local communities.

Factors impacting negatively on them included difficulties with accommodation, Internet access issues, the lack of transport and financial problems.

The study, *Ruralization of students' horizons: insights into Australian health professional students' rural and remote placements*, was conducted by researchers from various university Centres and Departments of Rural Health, including UCRH North Coast (Dr Sabrina Pit).

"Health workforce shortages have driven the Australian and other Western governments to invest in engaging more health professional students in rural and remote placements," the authors said.

"The core concept identified from the thematic analysis was "ruralization of students' horizons," a construct representing the importance of preparing health professional students for practice in nonmetropolitan locations.

"Ruralization embodies three interrelated themes, "preparation and support," "rural or remote health experience," and "rural lifestyle and socialization," each of which includes multiple subthemes."

They added: "The study findings have policy and practice implications for continuing to support students undertaking regional, rural, and remote placements and preparing them for future practice in nonmetropolitan locations."

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GPs asked to share care for mental health clients

by Dr Andrew Binns

For some time there has been talk of Northern NSW Local Health District Community Mental Health (CMH) sharing the care of patients who require depot antipsychotic medication with GPs. This was to be aimed at the more mentally stable mental health patients. Some guidelines were discussed but never implemented.

Meanwhile, GPs have reported numerous instances of patients saying they no longer attend CMH and were therefore presenting for depot injections or for ongoing care including oral antipsychotic drug prescriptions.

Self-portrait of a person with schizophrenia, representing that individual's perception of the distorted experience of reality in the disorder. By Craig Finn (schizophrenia patient) (Plos Medicine) [CC0], via Wikimedia Commons CC0 1.0

Along with this service provision including a mental health assessment, appropriate mental and physical care is needed. Handover of responsibility has frequently occurred without a formal case history and management plan for their ongoing care being sent.

The potential list of risks with this process is long and GPs have increasingly been expressing concern about the lack of communication between CMH, GPs/practices. GPs within a practice can at times find themselves responsible for an unstable mental health patient's welfare, leaving the clinician vulnerable and at times unable to get local advice.

Public psychiatry access is not available in our region. Private psychiatrists may not be appropriate or available for GPs to access while the Acute Care Service is only for managing acute situations. The Mental Health Access line is far from ideal in advising GPs. Vital patient care can therefore be compromised when professional help is not available.

GPs are already seeing many mental health patients some of whom require regular oral or depot antipsychotic or other psychotropic medication. These in turn may have significant side effects including weight gain and the metabolic syndrome. This can lead to significant cardiovascular risk, often made worse by smoking, drug and alcohol use, poor diet and physical inactivity, many if not most of which are relatively common amongst people with significant mental health disorders.

In response to this in September 2017 NSW Health put out some **guidelines** for the physical care of mental health consumers.

In the forward, the Secretary Elizabeth Koff, stated:

'There is international recognition that the gap in life expectancy between people with a serious mental illness and the general population must be acted upon.

The cause of this life expectancy gap is complex.

Whilst death from suicide contributes to this life expectancy gap, the predominant causes are physical health conditions such as cardiovascular disease, respiratory disease and cancer.

Recognition of the importance of bringing mental health and physical health care together is at the core of providing holistic care for people with a mental illness. This requires action in the way that health services treat and support people with a mental illness and all those who assist them.'

Section3.1.3, 'Strengthening relationships with GPs', states:

"GPs should be considered an integral part of the mental health care team, particularly in terms of improving the physical health of mental health consumers. Developing shared care arrangements with a consumer's GP, or linking consumers with a GP in the area, should be a priority for mental health services. To support this, a strategy should be developed, at either a local or Local Health District."

The guidelines go on to suggest ways of improving communication with GPs. The North Coast Primary Health Network's GP Clinical Council representatives are well suited to lead the negotiations with the LHD's Mental Health team in order to develop a strategy, and plans are afoot for this to happen.

An educational process for LHD mental health staff and GPs would also be needed to implement such a strategy. Also appropriate joint funding would need to be sought to develop the strategy.

Developing a shared care model for GP based antipsychotic depot services as well as for other case managed patients is a highly complex but important issue for mental health consumers. With appropriate guidelines and pathways there is hope that current practice can be significantly improved.

Aside from the cost shift from State to Federal government – the former funds community and acute mental health services, the latter is responsible for GP services - a shared care model could well better serve a patient's mental and physical health needs.

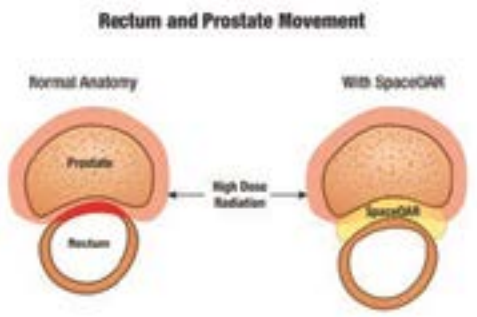
Genesis Cancer Care Queensland

Reducing Potential Rectal Side Effects in Prostate Radiation Therapy with SpaceOAR

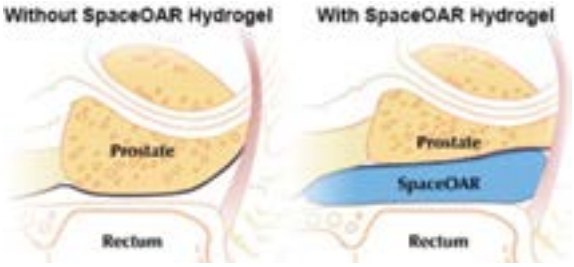
GenesisCare is partnering with the Tweed Hospital to provide SpaceOAR for men undergoing Radiation Therapy at our GenesisCare centres.

Radiation therapy for prostate cancer is daunting. The thought of the potential side effects that may come with radiation treatment can be a cause of anxiety. Here at Genesis CancerCare we are offering the latest technology to allay the fear of potential rectal toxicity.

Genesis CancerCare is pleased to offer SpaceOAR to suitable prostate cancer patients. SpaceOAR is a liquid that is injected between the prostate and rectum under ultrasound guidance. Once injected, the liquid solidifies within seconds into a hydrogel that pushes the rectum away from the prostate, thus reducing potential toxicity.



This procedure reduces radiation exposure to the rectum and related side effects during Intensity Modulated Radiation Therapy (IMRT) or Volumetric Modulated Arc Therapy (VMAT) for prostate cancer, available at GenesisCare locations.



SpaceOAR is placed by urologists during the same procedure as gold fiducial marker seeds (used for positioning the prostate during radiation therapy treatment) are placed. As well as now being available at Tweed Hospital, this procedure is also offered at Gold Coast Private Hospital and John Flynn Hospital.

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Looking after the Community

by Dr David Guest

Building a community for those with a common interest is often a difficult task. David Guest reports on a, perhaps unlikely, community to have made great progress in this area.

Linus Torvalds may not be well known as Bill Gates or Steve Jobs but his computer operating system, Linux, runs the majority of computers in the world.

Linus has a reputation for being "grumpy" … I'm a bastard. I have absolutely no clue why people can ever think otherwise." And on his competitors - Microsoft isn't evil, they just make really crappy operating systems."

Linus is determined to create the best software possible but making everything work together where there are over 15 million lines of code in the kernel, the heart of all operating systems, is too much for any one person. There are teams of maintainers for the various subsystems and ultimately they all answer to Linus. If they stuff up, they will incur his wrath.

As on open source computer projects, contributions to the linux kernel are made freely. If they are accepted by Linus they make it into his kernel. If they are rejected you can put them into your own kernel without almost no restrictions. The only problem with this is nobody else will care and maintaining your own kernel is clearly a difficult task.

The fights on the Linux Kernel Mailing List (LKML) are **legendary** and some contributors find the venom intolerable and leave. The resulting loss of talent is of great concern to some within their community.

Similar problems have occurred in other open source projects and managing the community is now recognised as an important issue for most large open source initiatives.

The linux project was started in 1991 and achieved some traction amongst computer enthusiasts in the late nineties. Well known Australian software developer, **Rusty Russell**, financed the first meeting of Australian linux developers in 1999 with his bankcard. The event has grown over the years to become the annual meeting of **Linux Conf Au** (LCA). This year it was held at UTS, Sydney.

The **archetypal computer nerd** is a pimply teenage boy, typing away furiously in his parent's basement. However, times are changing and the LCA community has worked hard in recent years on being a more inclusive community. An increasing proportion of **the talks** were given by women, as were two of the four keynotes.

Throughout the conference, and even before, participants are made aware of the behaviours expected of attendees. The **Code of Conduct** and the **values of the Linux Australia community** are mentioned at each plenary and anyone with any concerns about safety or similar issues is encouraged to contact the organisers through the registration desk.

Container developer and open source advocate, Microsoft employee and LCA 2018 keynote speaker, Jess Frazell

So what might one learn at LCA2018?

You could join Fiona Tweedie talking at the **GLAM project workshop**. GLAM is not about fashion. The Galleries, Libraries, Archives and Museums initiative looks at ways of making better use of these municipal resources. Developing effective but free software is one focus but Fiona's talk looks

at ways non-technical people can help preserve and categorise Australia's print and sound archives.

Alternatively, one might prefer to take a trip back in history with Lilly Ryan to learn from **Wildman Whitehouse** how not to run a major project and maybe consider some approaches to increasing the chances of your project's success.

For something a little more up to date but equally pertinent, Katie Bell addressed **Why your bus is late**. She is thankful she no longer has to catch the 370.

If you're a little shy about public speaking Emily Dunham, DevOps engineer at Mozilla, told us why **You Should Speak** and how to "lean in" for the benefit of your community and yourself.

The fabulous Holden Karau, committer on the **Apache Spark** project, gave some hints on how to cope with **too many contributions to your project**.

Technical users interested in core operating systems boot sequences could join Alison Chaiken in **Linux: The First Second**, while Microsoft employee, Jess Frazelle hypothesised that 2018 will be the **year of linux containers on the desktop**.

Lightning talks are fast. The presentation technique traditionally uses 3 slides or 3 minutes, whichever comes first. With the death of PowerPoint, the slide number has increased to 30 but the 3 minutes is a constant.

One rule of presenting is never do a live demo. The technology will always defeat you. Undaunted by conventional wisdom Sasha Morissey demonstrated how to **generate C++ code using templates** within her allotted time.

Some of the brightest programmers on the planet come to LCA. Linus Torvalds himself

cont on P14

Looking after the Community

cont from P 13

turns up some years. It is a tribute to the community to hear their support for Emma Sprinkmeier, 15-year old schoolgirl and LCA volunteer give her first major talk, on her passion topic, **Vocaloids.**

The majority of graduates in medicine are women but the percentage for computer science is less than 25%. At the **Open Education Miniconference, Dr Nicky Ringland** discussed her efforts through the National Computer Summer School, as well as through online mentoring, to address that imbalance.

Dozens of other talks by women presenters from LCA2018 are available online. Thanks to a **team of AV tech volunteers** nearly all the presentations and workshops were recorded and **archived by the conference** and also usefully made **available on youtube**.

So what might one learn next year in Christchurch at LCA2019?

Well, you can learn lots of interesting things about kernels, boot sequences and blockchains. However, you could also learn how a bunch of weird techies are transforming their community to embrace gender equality, diversity and inclusion. See you **maybe**?

Doctors' suicide risk report released

'Culture' and 'compassion' were the key themes raised in the final report of the National Forum on Reducing Risk of Suicide in the Medical Profession, released at the end of December 2017.

The forum was convened in September by the AMA and Doctors' Health Services Pty Ltd (DrHS), a subsidiary of the AMA that is funded by the Medical Board of Australia.

The report records the considerations and recommendations of the 82 doctors nominated by key medical stakeholder organisations who attended the forum.

Under the microscope were the individual, organisational, and environmental issues seen to impact negatively on the emotional health and wellbeing of doctors.

DrHS Chair, Dr Janette Randall, said, "The themes that emerged from the day were culture and compassion. We heard stories of psychological harm, mental illness, and suicide, which are the sad and tragic reality of the pressures of being a doctor in Australia today.

"Not enough doctors and medical students have a GP who they see regularly…"

"Importantly, we also heard stories of how doctors at the coalface are working on solutions to protect their own health, the health of their colleagues, and their patients.

"The strong overarching message from the

Forum was that cultural change has to come from within the profession and doctors must care about and value the health of their colleagues."

AMA Vice-President, Dr Tony Bartone, said many factors can affect how doctors and medical students cope with the stressors of their work roles.

"Not enough doctors and medical students have a GP who they see regularly, and not enough doctors engage in preventive health care such as healthy lifestyle, proper work-life balance, and regular check-ups – simple, yet vital, actions that can keep stress and depression at bay," Dr Bartone said.

"The stress can build up over time and, in worst-case scenarios, can lead to self-harm and suicide."

The facilitator of the Forum, Professor Simon Willcock, Clinical Director of Primary Care at the Macquarie University Health Sciences Centre, said doctors do not currently recognise and respond to illness in themselves or their colleagues.

"Across the profession, we have to get better at seeing the signs when matters like ageing, burnout, compassion fatigue, traumatic events, bullying, and harassment are eating away at our colleagues and ourselves," Prof Willcock said.

"These things affect our health and wellbeing and our effectiveness as doctors, and ultimately can affect the quality of care we are providing our patients."

A range of actions were agreed upon, including a public statement of intent to make the health of the profession a priority; developing education on how to be a 'doctor-patient' and how to treat medical colleagues when they are patients; providing advice, support and clearer pathways to assist all doctors to find their own GP.

By March, a 'Patrons' group of interested stakeholders will be formed in order to champion doctors' health, promulgate key messages among their professional sector, support key initiatives, and contribute resources where required to support implementation of the Forum's recommendations.

CPR Training where it really counts

Cardiac-pulmonary resuscitation is a compulsory part of accreditation and vocational registration. Dr Ruth Tinker favours a new service that ticks all the boxes.

Would you like to:-

- **build teamwork and clinical partnerships within your practice?**
- **help your team to get their compulsory CPR certification?**
- **review your in practice emergency protocols?**

The team at the Goonellabah Medical Centre recently arranged for their CPR training through the new service provided by UCRH, Lismore. The CPR Training Unit can come to your practice out of hours, usually in the evening of a business day.

CPR training at Goonellabah Medical Centre

Our nurses and almost all of our doctors took part. The modern equipment made it possible to accurately check that our techniques were effective. Getting the compression depth and rate correct takes a little practice and makes one realise how tiring two minutes of CPR can be. This in turn reinforces the message that the person doing compressions should be rotated every two minutes.

While the Guedel's airway is familiar, there are newer gadgets that can make the ventilation component of CPR more efficient. One was also reminded of the surprisingly little amount of air required for ventilation. Over ventilating and puffing up the stomach is not good for optimal outcomes.

It was then on to the two simulations designed to prepare us for a real world emergency. This is best practised in your own workplace, with your own team and setup. The experience was very instructive. We clearly had room for improvement.

As a result, we will be reviewing our written protocols and when the time comes we will also read them, using world famous, medical innovator Atul **Gawande's checklist manifesto protocol**.

CPR is literally life saving as one our doctors will attest and it is something you should try at "home". **Any dummy can learn it.**

Practices interested in having in surgery CPR training should contact::

Sharene Pascoe

CNC Emergency NNSWLHD

W: 66202156 M:0437789197

sharene.pascoe@ncahs.health.nsw.gov.au

Fluvax is on for young and old

Hoping to avoid a repeat of 2017's horror influenza season both state and federal governments are injecting significantly enhanced funding into pre-winter vaccination programs.

NSW will provide the flu vaccine free of cost to children aged six months to five years, echoing a strategy undertaken in Queensland last year.

Last year there were more than 12,000 confirmed cases of influenza in children under five years. The campaign will target 400,000 eligible children at a cost of $3.5m, and begin rolling out from April.

In the same month the Federal government will begin a campaign to boost the chances of Australians over 65 years avoiding flu. Two new "enhanced flu vaccines" - Fluad and Fluzone High Dose - will be offered, Health Minister Greg Hunt announced in mid-February. These target last year's flu mutation that caused or contributed to more than 1,000 deaths.

"We are pretty confident this will be better protection," he said. "The standard vaccine seems to protect well in younger people, but we are confident this will give better protection for the elderly."

**Image courtesy of Jeni Binns*

First do no self-harm – the new "Physician's Pledge"

by Dr Jane Barker

This article was first published by Dr Jane Barker, NRGPN Board member, on **To Medicine with Love.**

Last week I met up with a newly graduated medical student whom I had mentored during his training. He had missed the award ceremony for his medical degree for personal reasons. When we met, without prior discussion, we both produced from our pockets a copy of the "Physician's Pledge", the newest version of the Hippocratic Oath, having independently decided that the time was right to read it together.

We walked up to the Byron Bay lighthouse and together stood on the hang-gliding platform, looking out over the stunning view from Tallows Beach to Broken Head, and together read the pledge: "I solemnly pledge to dedicate my life to the service of humanity" … he, ready to launch into his career, me coming towards the end of mine; a handing over of the baton, as it were. I reflected on the words, what they had meant in my life and asked myself whether I had upheld them.

It was a special moment.

The Hippocratic Oath

The Hippocratic Oath was found in early Greek writing, 2500 years ago, and could still be relevant today, if adapted to take into consideration modern medical science and changes in societal values. There are several different early versions and different translations. Back then it was an oath made to the Ancient Greek Gods:

> *"I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract:"* [1]

The Hippocratic Oath is the first known record of an expression of medical ethics and covers many issues which are at the heart of medical practice today; and the recital of the Physician's Oath has for many years been a part of the graduation ceremony of new physicians. Over the years it has been modernised and the newest version, the Physician's Pledge, is based on the Declaration of Geneva, published in 1948.[2])

Portrait of Hippocrates from Linden, Magni Hippocratis...1665 Credit: Wellcome Library CCby 4.0

The European world of 1946 was recovering from the horrors of the 2nd World War. Of particular concern to the medical profession was the shocking involvement of doctors of several nationalities in torture and genocide. It was in this climate that the Geneva Declaration was published in 1948 containing the words:

> *I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.* [2]

The Declaration of Geneva has been revised six times since it was originally proposed. The world, and medicine itself, have changed so much over the past 70 years that newer versions are needed which retain the essence of the original oath of Hippocrates, but take into consideration the ethical and moral values of our times. The version I recited with my friend was not the same oath I made with my graduating class 44 years ago, but the newly minted "Physician's Pledge" published in October 2017.[3] A working party representing the World Medical Association spent two years formulating the new pledge which is secular in nature and the WMA hopes that it will be adopted across the medical world.

Changes to the new pledge

Under the umbrella promise to "dedicate my life to the service of humanity", the pledge follows the principles of patient centred medical care, making a change to the 1948 Declaration by vowing to "respect the autonomy and dignity of my patient". This is a welcome move away from a past of paternalistic Medicine.

Unlike the 1948 version, in this modern pledge there is no specific reference to abortion or euthanasia, or indeed the inappropriate prolonging of life. These are among the most significant issues in modern medical ethics. Instead it pledges to "maintain the utmost respect for human life" and "not to use my medical knowledge to violate human rights and civil liberties, even under threat".

While there is no longer reference to brotherhood, the pledge vows to "give to my teachers, colleagues, and students the respect and gratitude that is their due".

Respecting and valuing students is an important addition, as students often feel they are not treated with dignity. My own belief is that we cannot expect our students to practise with the compassion and caring our patients need and deserve, unless we serve as role models of this in our own interactions with patients and colleagues, and our treatment of ourselves. We should indeed treat our students with compassion and caring which involves valuing, respecting and honouring them. This new clause challenges our universities and teaching hospitals to do just this.

First do no self-harm

The pledge once again demands the altruism so often thought to be a vital part of our profession – "the health and wellbeing of my patient will be my first consideration" – but for the first time it includes a pledge to care about ourselves – "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard".

Primum non nocere – first do no harm – was in fact not included in the original

Hippocratic oath as is often presumed, but as Medicine advances it becomes increasingly relevant. To first do no self-harm can be equated to the DRS ABCD[4] used in Adult Life Support training. The first D is a reminder to move the patient away from anything which is dangerous to them or the practitioner. In this context we could first consider danger to the practitioner.

Medicine has long been considered a demanding profession, in fact as this pledge implies, much is asked of us. We are aware that the stressors of medicine have taken a high toll in burnout, anxiety, depression, alcohol and substance use and suicidality. A doctor practising with these impairments puts the wellbeing of their patients at risk. While in this pledge the doctor is asked to care for themselves for the sake of the patient, doctors, no less than any other people, deserve to care for themselves for their own sakes.

Our profession should not ask so much of its doctors that they are put at risk of mental health issues and suicide. By including self-care in the new Physician's Pledge, advocacy for self-care cannot be treated as a fluffy add-on, or yet another thing that doctors have to do, but as an integral part of medical training and the responsibility of our colleges and institutions as well as ourselves. The welfare of our clinicians is of vital importance and we need to become a profession that truly cares for its own. If as the "caring profession' we do not do this, then we fail not only our patients and colleagues, but fail to set a standard for other professions, indeed for all workplaces.

It is worth taking a moment to ponder on this new pledge. Does it serve modern medicine? Does it ask us to change ingrained cultures in medicine? Has it the potential to better our profession? Is the pledge one that you yourself would ask our young doctors to commit to? Is it a pledge you could commit to yourself?

What can and must we do to create an environment in medical schools and hospitals which is supportive not only to our patients but to all staff equally, as well? This is the challenge and inspiration that the new oath offers to us.

World Medical Association Declaration of Geneva – The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

- I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
- THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
- I WILL RESPECT the autonomy and dignity of my patient;
- I WILL MAINTAIN the utmost respect for human life;
- I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient;
- I WILL RESPECT the secrets that are confided in me, even after the patient has died;
- I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
- I WILL FOSTER the honour and noble traditions of the medical profession;
- I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;
- I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
- I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;
- I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
- I MAKE THESE PROMISES solemnly, freely, and upon my honour.

References:

1. Ancient Greek version of Hippocratic oath
2. Declaration of Geneva 1948
3. Physician's Pledge October 2017
4. DRS ABCD

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

On a clear night you can see forever *

by Robin Osborne

Dr Stephen Moore and his backyard observatory

For weeks the weather was dry and the sky cloudless, leading Northern Rivers residents, especially gardeners to believe - foolishly, of course - that it might never rain again.

Then, on the afternoon of 31 January 2018 the clouds built up and by dusk there was no sky to be seen. No sunset, and more importantly, no full moon starting to rise.

Amidst all the media hype, the local area, and a good deal of eastern Australia, would miss out on seeing what was billed a once in a lifetime event, a Super Blue Blood Moon

With a desperate hope of glimpsing this rare event, the first total lunar eclipse since 2015, many locals stayed up, or roused themselves, at midnight, but to no avail.

Groans of disappointment, even anger, flooded social media, further fuelled by links to a host of websites where sky gazers posted stunning images of the Moon over the Pyramids, the mosques of Istanbul, and much of the USA (thank you Steve Scanlon from Locust, New Jersey who snapped the event at the civilised time of 6.53am).

Trifid Nebula (M20), a complex nebula and star-forming system 5200 light years away.

If we felt let down, how devastated were the ardent astro-photographers who spend hours each week looking into space and recording the movements of the galaxies and planets that circulate above us?

GP*Speak* sought comment from Stephen Moore, consultant physician with visiting rights at Lismore Base Hospital. A long-time local resident, Stephen has built a backyard hill-top observatory with a 3000mm focal length telescope that makes the Moon, Jupiter and rest of them seem close enough to touch.

"When you rely on the weather to behave you must be prepared for disappointment," he told us from the confines of his observatory dome a week after the Moon, or more accurately the clouds, had let us down so badly.

"It was perhaps a bit overstated by the media, although it's good to get people looking up at the sky. The next lunar eclipse will be almost as good, and they are not infrequent. The next one is in the early hours of the morning on July 28.

"The great thing about lunar eclipses is that they're a global occurrence. You don't have to travel to see them, as distinct from solar eclipses that are only visible from certain places on earth."

For the record, the next total solar eclipse visible from Australia will be in 2028. Not content to wait, Stephen plans to travel with his wife Gabrielle to Chile in July 2019 where his adult boys will join them to witness the blacked-out Sun.

In August last year two of their sons (and one of mine) got the taste for solar eclipsing from the mid-north states of the USA, which provided an ideal view of the new Moon blocking out Earthlings' view of sunlight. Festivals lasting well beyond the few minutes of darkness were planned around it.

Stephen's interest in the universe above dates from childhood in Canberra, a place that in those days had minimal light pollution to interfere with star-gazing. But his passion dates back to his 40th birthday when he gave himself a small telescope as a present.

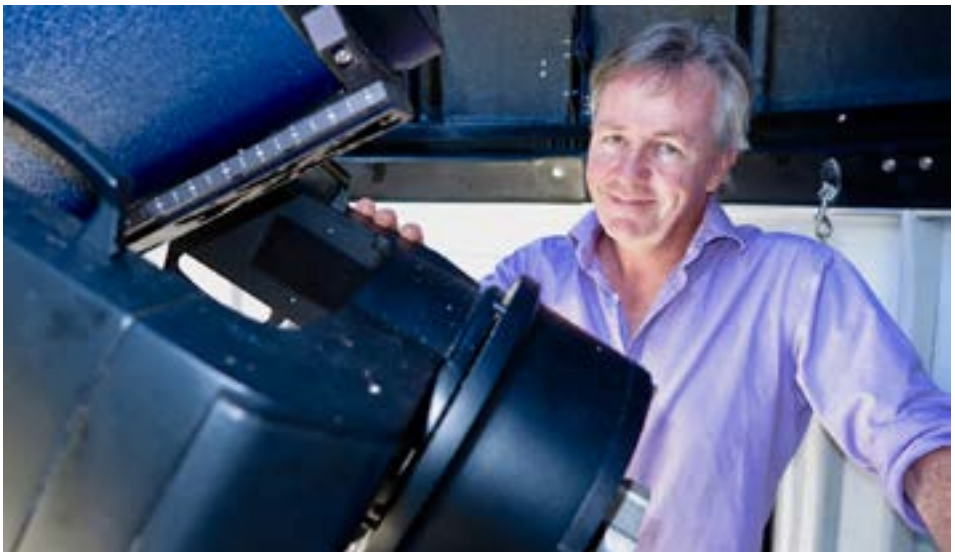
He was hooked, although his advice to beginners is to start with a good set of binoculars - "It's amazing what they can reveal, especially in an area like ours where the skies are so dark and clear - mostly, anyway!"

Astro-photos by Dr Stephen Moore

If you decided to pursue the interest further, you could follow in Stephen's footsteps and undertake postgraduate study in astronomy. At the time of interview he was set to finish the last of 12 units in a Masters degree program offered by Swinburne University. The tutors, Stephen said, are well known on the world stage.

"I've been doing it for fun," he added.

"It forced me to another level, studying the topics you would expect, the movements and inter-relationships of the planets and galaxies, and so on, but also things like archeoastronomy, which looks at places like Machu Picchu and Stonehenge."



He has visited both sites and has superb photographs - in self-made frames - mounted on the walls of chez Moore.

Total lunar eclipse as viewed from the Northern Rivers in August 2007.

While assignments for the course need not include night sky images - not everyone has a backyard observatory and high-level photographic skills - Stephen has delighted in including a range of images.

He uses a Canon 60da, a 'cooled dedicated telescope camera', and a planetary camera that produces video-like images that can be stacked together to provide an enhanced shot.

Nocturnal lightshow - full Moon and lightning seen through clouds.

As specialised as this may sound, neither the study program nor his ability behind the shutter equips him to be a professional astronomer - Lismore Base take heart.

"That's a whole other level, involving PhDs and beyond, with access to the telescopic equipment at the observatories managed mostly by the main universities.

"I'm just an enthusiast, and that's why it's such fun. No pressure to make discoveries or have a star named after me."

Asked whether evolutionary developments on Earth are being replicated in the heavens, Stephen says that even up there things are changing, if rather slowly.

"The Moon is slowly spinning away, and there will come a time when it will no longer completely block the Sun as seen from the Earth's surface."

Should we hold our breath?

"Probably not, it might take several million years."

* With apologies to playwright Alan Jay Lerner

Why are SMSFs so popular?

A popular choice for managing superannuation is to take personal control via a self-managed superannuation fund (SMSF).

Although membership is limited to a maximum of four people per fund, the Australian Tax Office (ATO) reports there are over half a million SMSFs, representing more than a million members. It estimates the value of assets held within SMSFs is more than $670 billion!

So, what's the attraction? Below are some key advantages of managing your own super:

CONTROL - With SMSFs, all members of the fund are also trustees and are therefore responsible for all decisions. They are required to manage the fund in accordance with current superannuation laws.

FLEXIBILITY -Trustees can seek the assistance of administrators and licensed advisers to help them meet and maintain their legal responsibilities in the running of their fund or they can do it all themselves.

INVESTMENT CHOICE -A much wider range of investments is available to trustees than may otherwise be offered by retail or industry funds. This allows maximum flexibility in investment selection, especially for geared investments and non-traditional assets like artwork, bullion and certain types of landholdings. There are, however, strict rules that govern how personal use assets and collectibles held in SMSFs are stored.

DIRECT PROPERTY - An SMSF can invest in direct property, whereas retail funds usually cannot. In addition, a business property owned outside superannuation can be transferred into an SMSF. For many self-employed people, having their SMSF own their business premises can make financial sense.

COST SAVINGS - SMSF fees are usually fixed whereas retail super funds are charged as a percentage of the account balance so for accounts over for example, $250,000, it may be more cost effective to establish an SMSF than to use a retail fund.

TAXATION - SMSFs can allow trustees to take a more tailored approach to managing taxation, especially when it comes to capital gains tax.

INSURANCE - SMSFs can hold life, temporary and permanent disability insurance on their members. This can be a tax-effective way of managing both the cost of the insurance and any future insurance payouts.

ESTATE PLANNING - The trust deed for an SMSF may allow for binding death benefit nominations. A will can be challenged in court, but under a properly executed binding death benefit nomination trustees must pay a death benefit as directed. This can provide greater certainty in the distribution of assets.

Despite the detailed legal responsibilities attached to SMSFs, it is clear that many people find the ability to manage their retirement nest eggs highly rewarding. Although there are many things to consider when converting your super funds to an SMSF, the added choices, flexibility and cost effectiveness may outweigh the additional time taken for administrative purposes.

Contact us if you would like more information to help you determine if a SMSF might be right for you.

TNR Thomas Noble & Russell
Accountants | Auditors | Business Advisers

TNR WEALTH MANAGEMENT

Should you have questions regarding accounting or tax advice, wealth management/creation, superannuation, insurance, retirement or other financial planning need, please call us on 02 6621 8544 or visit tnr.com.au or tnrwealth.com.au

Recycling helps Vinnies help the needy

The largest clothing recycling centre in regional NSW helps fund St Vincent de Paul's social works programs.

Story: Robin Osborne

Photos: Jacklyn Wagner

Every day around 10 tonnes of discarded clothing and piles of sundry household items are placed in, or less happily beside, Vinnies collections bins throughout the North Coast and other parts of NSW.

First dibs on this mountain of material goes to the Vinnies shop volunteers who sort through the donations and set aside clean, undamaged items for sale in one of the 27 shops between Tweed Heads in the north and Laurieton in the south.

"After some sprucing up these first-quality items go on sale in local Vinnies shops," according to Angelo Grande, the Society's Recycling & Waste Management Facilitator for the past 16 years.

"Thanks to the bargain prices they go quickly out the door."

A small quantity of goods, soiled or damaged, must be sent to landfill, with the remainder being transported to the Vinnies recycling centre in the Lismore suburb of Goonellabah.

The centre, occupying 1600 square metres, is named after Matthew Talbot, the 19th century Dublin ascetic who is an inspiration for ex-alcoholics worldwide. It is the largest such facility in regional NSW, handling one-fifth of the state's total clothing donations.

Toys, household goods and other recyclable wares are sent to the Vinnies Buy Back Shop, next to the recovery centre at Murwillumbah tip. Some items – from luggage to car seat restraints - are sent overseas, mainly to Papua New Guinea, Australia's nearest neighbour.

PNG, along with several east African countries, is also a destination for the tonnes of reusable clothing that the centre reprocesses.

Angelo Grande's team of twenty, many on JobStart or other supervised programs, start with sorting wearable clothes from clean but tattered items that, shorn of buttons and zippers, will be blade-shredded and sold in

Recycling centre manager Angelo Grande and the team with compacted bales of clothing bound for PNG and Africa.

Frances Lollback cutting unwearable clothing into saleable rags for industry and homemakers.

Bev Garraway and Maria Delaney sorting some of the 10 tonnes of clothing that arrives at the centre each day.

5kg or 10kg packs known as 'Vinnies Bag O Rags'. These are a mainstay for painters, mechanics, car detailers and DIY home improvers.

The bulk of the usable clothing is folded and bundled together for compacting into 210 kg bales using a converted wool press, one of the facility's cannily adapted pieces of equipment.

These huge packs are moved by forklift to waiting trucks that will take them to shipping containers on the docks and on to outdoor markets in PNG and Africa where the recycled donations will be sold to local people at affordable prices.

"This is a recycling effort that starts with individual Australians and moves to an industrial scale," said the North Coast President of St Vincent de Paul Society Yvonne Wynen.

"Each year we are rescuing nearly half a million tonnes of clothing that would otherwise go to landfill. The precious funds we earn are used to help local people doing it tough.

"This includes support with accommodation, food and pharmacy bills, the needs of children, drop-in facilities for homeless people... all made possible through recycling goods that society discards. It's a win on every level," Ms Wynen said.

Robin Osborne is St Vincent de Paul's regional communications manager, Jacklyn Wagner is former chief photographer at The Northern Star, Lismore.

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GPspeak

PO Box 498
31 Uralba Street
Lismore NSW 2480
Telephone (066) 22 4453
(066) 21 7231
Facsimile (066) 22 2151

Editor: Hilton Koppe

Monthly newsletter from the Northern Rivers Division of General Practice (NSW) Ltd

So Far, So Good

Our Division has been operating for six months, and progress has been made in many areas. Five projects have received funding for this year, more than for most other rural Divisions. Regular contact is being made with the Medical Staff Councils in the area. Their representatives have participated at the last three Divisional Executive meetings via teleconference, and this improved communication will help to make the Division much more effective.

Each week there are more and more requests for general practitioner input into a whole range of issues, including Women's Health, Pain Management and Immunisation, etc. We have been referring these matters to members of the Division with particular expertise in these areas. Would you like to act in this capacity for a special interest of yours? Please let us know.

A great breakthrough occurred at the recent meeting with Mark Cormack, the new Director of Primary Health Services. He agreed in principle that funding should be made available for our members to have an input in Primary Health Care planning in our region. It was a relief at last to have a local health administrator acknowledge that we deserve to be paid to sit on these Committees, and that our input is essential to Primary Health Care planning.

The Rural Divisions Co-ordinating Unit has been lobbying on our behalf with regard to the difficulties now faced by GPs doing obstetrics. Please contact us if you have any questions regarding this.

Elections for the Executive Committee will be held soon. We are looking for greater input from other members. In particular, we would like to see representation from both women and part-time members. Funding is available for participation on the Executive, and much of it can be done from home by teleconference.

Obstetrics

Medical defence premiums have doubled in the past year for GPs practicing obstetrics. A preliminary RDA survey has revealed that at least 50% of rural GPs will cease obstetric practice within six months and may consider the burden of litigation expenses will drive them out of rural practice.

Early this month a sub-committee was formed to develop a framework to respond to current issues specifically for rural GPs practicing obstetrics and to develop a plan of attack for the situation generally. The idea of a sub-committee grew out of an RDCU teleconference meeting. The members are Drs Louise Baker and Mark Adamski (Central West Division), Les Woolard (Barwon Division) and Richard Abbot (Hunter Rural Division). This group has membership of both the RDA and the RDCU to address the current situation.

In the broader political context the Government has commissioned the Tito Committee to investigate

(continued inside

GPspeak has been delivered as a service to the Division by Sullivan & Nicolaides

GP*Speak* turning 25

Andrew Binns with the first-ever issue of GP Speak.

GPSpeak has now reached a milestone in the life of any publication – this issue marks the 25th year of our quarterly editions... a ton of magazines in every sense of the word.

In line with changing technologies we have gone from 8-page black and white versions to 32-page colour and online versions today. Publication dates have been timed in accordance with the seasons of the year. Cover designs have ranged from clinical images through infographics to portraits and stunning photos such as Stephen Moore's picture of the Moon for this issue, and Frank Hurley's extraordinary shot of Shackleton's ice-bound vessel in the previous issue.

As the magazine's unofficial archivist I have saved copies of every issue and occasionally delve into them to look up some historical event within our GP culture. A lot of clinical articles are mixed in with medical politics, opinion pieces and general interest stories.

Over this time we have had five editors: Hilton Koppe, the late Katherine Breen Kuruczev, Aaron Bertram, Janet Grist and now Robin Osborne. They have been well supported by an active editorial committee and a wide range of contributors.

GP Speak is truly a team effort and an important part of that team are our valued advertisers, without whom we would not be able to meet expenses. Our extensive circulation, in both printed form and online, and our prime readership, present excellent value for their promotional outlay. We thank them for their support.

Over the years we have taken up various issues of relevance and even lobbied politicians, including Tony Abbott when he was Health Minister. Sitting under a tree at the Casino Hospital with Tony in his lycra 'pollie peddle' outfit, we successfully negotiated a deal to allow GP training registrars from urban areas to do some of their training in a rural area such as ours. This was in response to the desperate need to address our GP workforce crisis.

Indigenous health and its close relationship to culture has been a subject of particular interest. All local GPs have Aboriginal patients, and many of us work either part or full time in Aboriginal Medical Services. GP Speak will continue its commitment to covering this important subject.

This newsletter-turned-magazine has played a key part as the voice of GPs in the Northern Rivers. It has helped us work as a united group dedicated to serving our community. Many names mentioned in that first 1994 edition are still providing primary care leadership today. Up and coming GPs and allied health professionals will hopefully be inspired to pen articles and sustain the magazine's reputation for fairness, incisive and informative articles, and relevance to the unique society that we call the Northern Rivers.

Casino cannabis project scores $2.5m govt grant

Perhaps helped by a late-December name change from the frivolous PUF Ventures to the more medical sounding Solaris Nutraceuticals*, the company that intends to grow and produce medical grade cannabis in a 9.3ha glasshouse operation in Casino has received a $2.5 million Federal grant.

The huge score was announced by the Federal MP for Page, Kevin Hogan, as part of a raft of grants for nine job-creating projects - Solaris claims 280 jobs will eventuate. These cover such disparate industries as blueberry growing for export, macadamia processing to make nut-based cheese, and expanded aged care in Kyogle.

A report on the company's plans was published in the **previous edition** of GP Speak (Summer 2017). This followed Richmond Valley Council's open-armed welcome and undertaking to enter into a 'strategic partnership' with the business whose home base is Vancouver, Canada.

According to the local company's CEO Michael Horsfall, "The new name reflects our focus on distinct innovations to provide medicinal cannabis grown under the Northern Rivers Sun... In addition to our name change, you will see a fresh new look and feel to the corporate image of the company which reflects the innovation, quality and environmentally sustainable products to be developed in our glasshouse and manufacturing facilities."

A statement from the company's head office said "applications for a medicinal cannabis license for the Northern Rivers Project in Australia, for both cultivation and production, cannabis research license and manufacturing license have been accepted by the Office of Drug Control."

The ODC, an Australian government body, advises that, "Medicinal cannabis products will only be available for specific patient groups under medical supervision."

So far a small number of cannabis-related prescriptions have been issued in Australia - estimates suggest less than one hundred. Pain management and appetite stimulation are among the main reasons.

It remains to be seen how future demand will soak up the anticipated production at the facility - 100,000 kg per annum at full capacity - even if clinicians warmly embrace the therapeutic (not to mention psychotropic) benefits of cannabis sativa.

A pointer to the apparent supply-and-demand anomaly may come in another of the company's lengthy public statements: "Assuming recreational cannabis becomes legal [as it now has in various US states]... it is suggested that the cannabis market in Australia could grow to $9 billion over the next 7 years."

The next question then is whether 'medicinal', along with 'Nutraceutical' may not be smokescreen terms to disguise the true purpose of the operation. And in consequence whether the National Party's local MP, and the Liberals' Minister for Regional Development, Dr John McVeigh (PhD in agribusiness), whose parties are staunchly anti decriminalisation, may not have handed out a large sum to assist dope growers.

If so, perhaps the door will open for a similar, if less ambitious operation, in Nimbin, where the unemployment rate is even higher than in Casino.

* A seeming misnomer, as the word is used to describe medicinally or nutritionally functional foods, according to various **definitions**. "Nutraceuticals, which have also been called medical foods, designer foods, phytochemicals, functional foods and nutritional supplements, include such everyday products as "bio" yoghurts and fortified breakfast cereals, as well as vitamins, herbal remedies and even genetically modified foods and supplements".

A Cannabis sativa leaf - Image By Christopher Thomas CC BY-SA 3.0, Wikimedia Commons

Frustrated patients shop for pot

Although Australian practitioners can legally prescribe medicinal cannabis for a range of conditions, the great majority of patients who feel they might benefit are turning to the black market for their supply.

This disturbing claim was raised at a recent meeting between RACGP president Dr Bastian Seidel and the United in Compassion charity whose primary mission is "advocating for patient access to Full Spectrum herbal medicinal Cannabis extracts and dried herb Cannabis; in a manner which is safe, effective, affordable, equitable and favourable for patients, for the dignified relief of suffering."

At present only a small number of people have been able to access cannabis through legal prescription - estimates range from 100 to 300. In frustration, many more - up to 100,000, it was suggested - are turning to illegal suppliers whose grade of product comes with no guarantees.

While Dr Seidel said he would not consider medicinal cannabis as "the first choice of treatment for any medical condition", he believed it "might well be a treatment of last resort for quite a few of my patients."

Emergency physician David Caldicott, a well-known critic of Australia's drug laws, notably in regard to bans on pill testing at music festivals, likened the nation's current experience with medical cannabis to a "train wreck". He said a range of developed countries, including Israel, Canada, and Holland, had fared much better.

Attendees at the meeting spoke of government hypocrisy, saying legalised prescribing was just a veneer over continued prohibition.

Dr Seidel said, "The regulators failed us by making Oxycontin so widely accessible, on the PBS. Now we have a drug we know doesn't work, is causing harm, and is still on the PBS. We should get it right for medical cannabis once and for all."

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WEB: - www.coastalvascular.com.au
EMAIL: - info@coastalvascular.com.au

Dr Dominic Simring
B.Sc. (Med) M.B.B.S (Hons) F.R.A.C.S (Vasc)
Provider No: 2382248J
VASCULAR AND
ENDOVASCULAR SURGEON

Dr Anthony Leslie
Bsc, MBBS, FRACS
Provider No: 253312LL
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Consulting Locations

Lismore – Level 2 Suite 4, St Vincent's Specialist Medical Centre, 20 Dalley Street
Ballina – John Flynn Specialist Suites, 79 Tamar Street
Casino – North Coast Radiology, 133-145 Centre Street
Grafton – Specialist Suites, 146 Fitzroy Street
Glen Innes – East Avenue Medical Centre, 39 East Avenue
Armidale – 3/121-123 Allingham Street
Tugun – Suite 2B, John Flynn Medical Centre, 42 Inland Drive

Education sessions - *Wound Assessment & Management*

These sessions for practice nurses cover issues about dressings, compression and bandaging for patients with diabetes, venous and arterial disease. Nurses working in general practice and community nurses are invited to attend.

Sessions run Monday and Tuesday from 9am to 1pm and include the Vascular Surgeon and our Practice Nurse. Please call Kerry Harper (Practice Manager) on 02 6621 9105 / 02 6621 6758 for details.

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Govt moves to control after-hours cost blow-out

Following recommendations by the Medicare Benefits Schedule (MBS) Review Taskforce the federal government is moving to reduce expenditure on often-notionally urgent after-hours home visits by doctors, which increased by 157 per cent between 2010–11 and 2016–17.

Announcing the changes, Health Minister Greg Hunt said, "There is no clinical explanation for the large increase, but rather the growth has been driven by a corporate model of largely advertising on the basis of convenience, rather than medical need."

The changes are in response to concerns raised by GPs that some doctors who are not GPs are providing urgent after-hours care, and that some treatments being claimed as urgent are not genuinely urgent.

The minister explained that the Taskforce found access to urgent after-hours care should be used "only when necessary and that funding should be appropriate to the level of care being provided."

The amended after-hours arrangements will mean doctors are able to provide the best care to their patients, and that after-hours services are provided by an appropriate doctor to people who require genuinely urgent treatment, the minister said.

The Medicare rebate will be adjusted to better reflect the qualifications of the doctor providing the urgent after-hours care to patients. All savings will be reinvested into Medicare.

Services provided in rural and remote areas will not change, in recognition of the difficulty Australians in these areas can face in accessing after-hours care. GPs and doctors in regional and rural areas will receive a higher rebate. Non GPs will have their rebate adjusted in stages over coming years.

All GP services that operate after-hours will continue to be able to treat patients

A doctor exacting payment for a house-call from a disgruntled patient. Lithograph by H.W. Bunbury. Wellcome Library, London. CC by 4.0

under Medicare using any of the 24 standard after-hours items. The Government will also maintain current rebates for all doctors providing services between 11.00pm and 7.00am.

RACGP President Dr Bastian Seidel said, "The changes are pragmatic, evidence-based and they do incorporate the substantive feedback from the medical profession and patients.

The Medicare rebate will be adjusted to better reflect the qualifications of the doctor providing the urgent after-hours care to patients.

"The changes to the Medicare rebates provide certainty to the after-hours sector in metropolitan as well as rural communities. We commend Minister Hunt for listening to the concerns of the RACGP and for implementing evidence based adjustments to after-hours Medicare rebates."

"The gold standard for after-hours care is a consultation with a specialist GP. The proposed changes to the Medicare rebates make that very clear. This can only be in the best interest of patients," Dr Seidel said.

The changes include limitations on "inappropriate advertising", with the practice of pre-booking urgent consultations before the after-hours period no longer being permitted.

AMA President, Dr Michael Gannon, said the Government's much-needed reforms to after-hours primary care should ensure that after-hours GP services are better targeted towards patients with genuine clinical need: "Poor models of after-hours GP care can fragment patient care, result in poorer outcomes for patients, and burden the health system with additional costs... the reforms announced today should help address these problems."

Link to Australian Government document - Improving quality in after hours GP services

Link to Australian Government document -taskforce recommendations

AMA's pre-Budget submission

In mid-December 2017 Dr Gannon released the **AMA's Pre-Budget Submission 2018-19** that urged the Government "to look at all health policies as investments in a healthier and more productive population."

Dr Gannon said, "The conditions are ripe for a new round of significant and meaningful health reform, underpinned by secure, stable, and sufficient long-term funding to ensure the best possible health outcomes for the Australian population."

Adding that, "The Medicare freeze will be lifted gradually over the next few years," he said, "The next Budget provides the Government with the perfect opportunity to reveal its health reform vision, and articulate clearly how it will be funded...

"The review of the MBS is an ambitious project. Its methods and outcomes are becoming clearer. Its best chance of success is if the changes are evidence-based and clinician-led and approved.

"A new direction for private health insurance (PHI) has been determined following the PHI Review. We must maintain flexibility and put patients at the centre of the system, but recognise the fundamental importance of the private system to universal health care."

Sydney's Chinese community celebrating the Year of the Dog. Photo: Andrew Binns.

Welcome to 2018, the Zodiac Year of the Dog.

The most recent Dog year was 2006, meaning that the youngest 'Dog' will be turning 12 (unless born in January-early February before the fireworks began exploding).

At the other end of the spectrum are 84-year olds, born in 1934, and it is this cohort that may be the most likely to be visiting their GP.

Next Dog patients in the queue would be those aged 72 (born 1946).

Age may indeed be the main factor, as statistics suggest, although there is a belief that favourable fortune seldom occurs in the Zodiac year of your birth.

According to those who predict such things, these septua- and octo-generians are likely to suffer hepatic and gall diseases, anxiety disorder, heart problems and hepatobiliary diseases.

Staying calm is recommended, as is "thinking much and speaking little".

However, all Dogs need to be careful when trying to tick off some items on their bucket lists. It is believed inadvisable to be climbing mountains, rafting and bungee jumping. No doubt you can think of plenty of other things to avoid, whether Dog or not.

For Dogs seeking holiday advice, the pundits are suggesting "a villa resort near river and forest", which sounds enjoyable whichever animal year is your destiny.

Book Reviews ... by Robin Osborne

Brain Rules for Ageing Well

10 principles for staying vital, happy and sharp

John Medina

Scribe 262pp $32.99

Judging from the photo on his media release, NY Times bestselling author Dr John Medina is a cheerful, middle aged chap who has clearly delighted in crafting advice aimed at helping us all - regardless of age - to live well into our advancing years.

An affiliate professor of bioengineering at the University of Washington School of Medicine, he has considerable experience in brain research, and knows a thing or ten about how we might stay 'vital, happy and sharp' into our later years.

Impressively, he attributes Sir David Attenborough as his mentor. A glimpse at almost any Australian television station's current programming will attest to the value of Sir D as a role model, not least because even on the box he seems to enshrine a good many of the principles that Dr Medina describes.

These include never retiring, engaging socially with others, eating sensibly and keeping mobile, sleeping appropriately, being sure to reminisce, and, wait for it, training your brain with video games. A specially designed program, NeuroRacer is highly recommended.

Falling is something to be particularly avoided, as it is "not a trivial issue for the elderly," as he hardly needs to reminds us, "for the two reasons they care about most: head injuries and bank accounts."

And the public health budget, one might add.

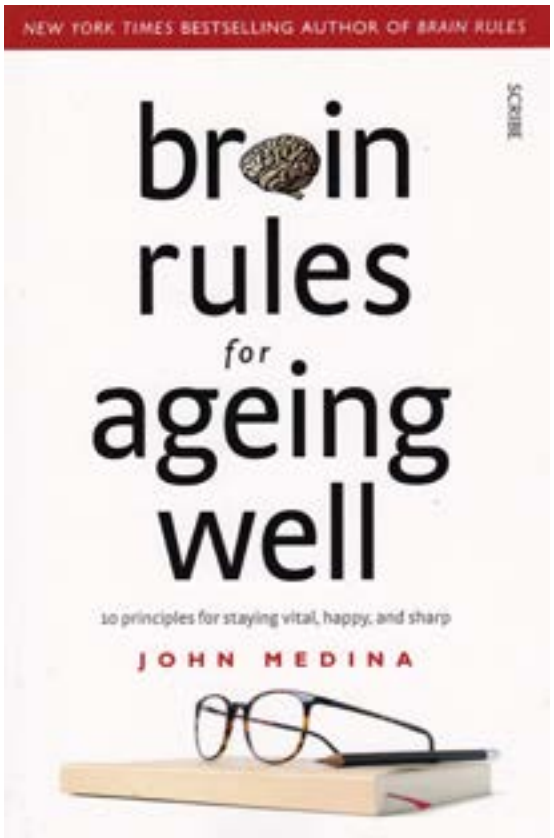
Proven prevention strategies include dancing of any kind, as well as such forms of ritualised movement instruction as Tai Chi.

This is much more than the usual self-help book, or a list of bleeding-obvious advice.

"I am going to use brain science to show how you can make life a surprisingly fulfilling experience - at least for your brain - in the years you have left... When it comes to causes of ageing, wear and tear is less detrimental than a failure to repair. And it is not inevitable that your mind will power down as the years pass.

"If you follow the advice in this book, your brain can remain plastic, ready to study, ready to explore, and ready to learn at any age."

Do you know what 'eudaimonic' means? One should, as it refers to "the sense of fulfillment that arises from achieving life's full potential as a human being."



This has consequences, as Medina says, for the more you feel it, the less likely you are to suffer from mood disorders: "Eudaimonic well-being functions like garlic against the

vampires of major depression."

Divided into sections covering the Social Brain, the Thinking Brain, Body and Brain, and Future Brain, this is an intelligent, empathic book, accessible and extremely valuable, whatever one's age.

The Story of Shit

Midas Dekkers (translated from the Dutch by Nancy Forest-Flier)

Text Publishing 292pp $32.99

"People who write books about shit are regarded with suspicion," observes Dutch biologist Midas Dekkers whose bluntly titled and graphically striking book may cause embarrassment if read openly on public transport.

He goes on, "If you want to make use of shit, no matter how, you have to handle it. And whatever you handle is likely to contaminate you, so faeces researchers can count of being the butt [pun intended, surely] of jokes, and cesspool cleaners are shunned."

In recent weeks I have been inundated by new books about the part of the body that for years has commanded the most attention - *The Whole Brain Diet* (Dr Raphael Kellman), *Empty Brain - Happy Brain* (Niels Birbaumer & Jorg Zittlau), and *Brain Rules for Ageing Well* (John Medina).

Credit is no doubt due to Oliver Sacks and Norman Doidge.

Rarely, apart from Giulia Enders' bestselling Gut, has the focus of authors moved below the neck, let alone the belt, or in this case, onto one of the body's two main waste products.

A Google search does not reveal anyone having written a history of piss, and even if they did, it's unlikely to be as enjoyable as Dekkers' occasional liquid digressions: "Drunks who urinate in the canals of Amsterdam in order to spare the city's monumental buildings can fall in the water and drown, especially at night when the townspeople are off the streets. Police officers who dredge up the bodies have little difficulty determining the cause of death: the guy's fly is wide open."

But back to shit... "Nothing resembles faeces more than food," he writes.

So why is shit held in such low esteem?

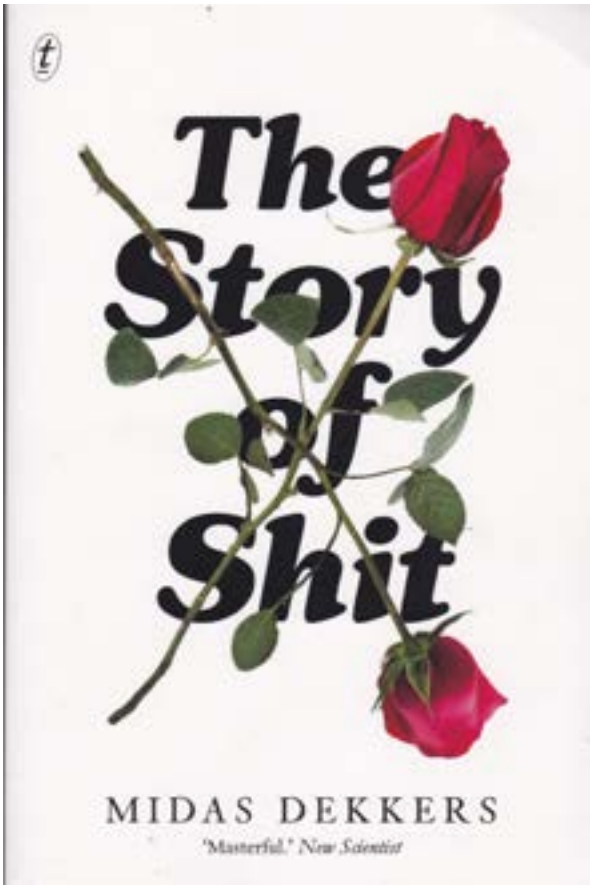
"What does it in for shit is mainly the lowly status of the organ in which it is housed, the intestines... Real life takes place in the intestines. Here the substances from the environment around us are converted into the energy that makes life possible... There are oodles of lower animals that don't have hearts or brains, but an animal without intestines doesn't exist."

So begins the author's remarkable foray into every imaginable aspect of diet, digestion and defecation, from the pleasure of having a good poo - up there with an orgasm, he says - to the design of lavatories (shun those without a window), cisterns and sewerage systems, the benefits of the squatting position, the value of both human and animal manure in agriculture, and a myriad descriptions of turds themselves.

"A well-filled stomach makes for good shitting... Shape is what a good turd has over such amorphous secretions as snot or ear wax. And the best shape for a turd is the worm shape, which it naturally assumes from the intestines that produce it.

"Intestine and turd fit together like a biscuit in its tin... We can thank our lucky stars that our turds don't clear a path to the exit in the shape of a cube or a garden rake... the turd looks as if has been pulled through a ring. And in fact it has been pulled through a ring. The anus."

For humans, defecating is not a "spectator sport" but animal behavior is more public - "Millions of people go outdoors three times a day to watch their dog shit. Passers-by and neighbours get to watch for free.... no war or disaster on the front page can match the lamentation about dog poo in the letters columns."



However, animal turds "work like a magnet", being able to both attract, notably in the mating season, and repel.

The author holds back on nothing to do with bottoms, farts and the act of shitting: "Isn't it delightful to let a well-lubricated turd slurp through your half-relaxed anus like a cake of soap through your hand?"

Even the subject of anal sex gets a look in, the author opining, "A man is lucky. He has a penis and an anus, which means he can mount and be mounted, although "Most men leave this option untried."

From constipation to toilet training toddlers, the work of Freud to faecal transplantation, this is a fascinating, milestone work that should run out of bookshops like shit off a hot shovel.

New UOW Clinical Placement Facilitator for Lismore

The University of Wollongong welcomes Rebekah Hermann to the Rural Medical Program in the role of Clinical Placement Facilitator in the Lismore Hub.

Supporting the Regional Academic Leader Dr Jane Barker, this role is based out of the University Centre for Rural Health (UCRH) where Rebekah has worked for the past two and half years undertaking a similar role in the delivery of rural medical programs to students of Sydney, Western Sydney, Bond and Newcastle universities.

As well as her experience in the health sector, Rebekah brings with her a diverse range of skills from the education sector where she has worked both as a school teacher in the Northern Rivers, and as a senior project officer for the Queensland Department of Education and Training.

Through her project work, Rebekah worked at improving access to quality educational resources for students living in rural and remote areas of the state through digital curriculum content delivery. Rebekah is constantly seeking new ways to achieve connectedness via online platforms and social medial.

Rebekah Hermann

Local to the region, and having spent the better part of her life on the Far North Coast, Rebekah brings with her a comprehensive knowledge of the local area and the individual communities which make up the Northern Rivers. Rebekah has many connections within the community, both professionally and socially, and draws on these wherever possible in the delivery of rural medical programs.

Rebekah is passionate about improving health outcomes for individuals, particularly in terms of accessing quality healthcare, and she is a passionate advocate for the training of rural health professionals.

The University of Wollongong is currently seeking interested General Practitioners to take on the role of preceptor to our Phase 3 Medical students. For more information on this rewarding role, please contact Rebekah for an information pack **Rebekah.hermann@ucrh.edu.au** or phone (02) 6624 0350

Invaluable clinical skills teaching from our local clinicians

The term 'clinical skills' refers to those clinical examination and procedural skills commonly used in the diagnostic and/or therapeutic management of patients in clinical environments, and is an integral and important part of everyday medical practice. They can be taught in clinical settings with real patients or in simulated settings.

Dr Anne Malatt - Eye Surgeon demonstrating the use of a slit lamp

Around 20 senior UOW medical students are fortunate to have the opportunity to learn essential clinical skills from our local clinicians each week. Ophthalmologists, allied health professionals, surgeons and GPs are just some of the committed educators who contribute to enhancing the students' abilities. Each week our program allocates clinical skills teaching time, which can be anything from using a slit lamp, navigating software programs, immunisation techniques to managing snake bites.

Teaching practical clinical skills requires using precise instructions to enable the learner to follow the process and to repeat and practice the skill. Most often this involves using both visual cues and text or audio prompts. It also requires the educator to provide appropriate and timely feedback to the student on their learning. It requires special skills in a medical educator and we are extremely fortunate to have a dedicated team of professionals in our region to assist students in the UOW medical program.

Each year Phase 3 or senior third year UOW MD medical students are provided with an opportunity for a 12 month longitudinal clinical placement in a regional or rural community. Places are offered in 11 locations across NSW, including three located in Grafton, Lismore and Murwillumbah, and these work closely with the North Coast University Centre for Rural Health . These north coast hub places are highly sought after by UOW medical students, due in part to the exceptional teaching programs and clinician support they receive. We rely on our educators, hospital clinicians and staff, as well as staff in GP clinics to support our program which enables students to achieve the best possible outcomes. We would like to extend a very big thank you to all educators and preceptors who contribute to the development of clinical skills in our UOW students.

Dr Charlotte Hall FACEM – Simulation workshop, Adult Life Support

Dr Charlotte Hall FACEM – demonstrating Intraosseous infusion

Plastering skills - Back Slabs

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