GPSpeak

‘Sugar-slave’ sister sings out

Inside -

GPSpeak

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Having grown up in 'sugar country' - Bundaberg, Queensland - Sheli Nagas now lives in Lismore where she works on various projects, including her jazz/country flavoured music. She is a long-standing outspoken advocate for her people, a unique ethnic group in the Australian community known as Australian South Sea Islanders, The 'ASSI' people are another 'stolen generation', in their case kidnapped and/or tricked into coming to Australia from the Pacific islands as slave labour for the sugar industry. Sheli is a pure-blood ASSI, not an Aboriginal Australian, but she is included in our regular Goori Country section because of her familial links with Goori communities locally and further afield. Cover photo: Robin Osborne

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Editorial

by Dr David Guest, Clinical Editor

I feel good. I knew that I would now.

I feel good, I knew that I would now.

So good, so good, I got you.

- James Brown, 'I feel good' (1964)

Easter on the North Coast - rain, washed out sporting events and the BluesFest. It's a tradition - mud, booze and blues, and let's admit it, drugs.

Previous issues of GPSpeak have championed Dr David Caldicott's advocacy of **voluntary drug testing for festival goers**. In April the **first tests** were run at the Goovin' the Moo festival in Canberra. The results showed that 50% of the illicit drugs tested contained substances such as lactose, sweetener and paint, while 50% were pure MDMA.

Two of the 85 samples were deemed to be potentially fatal. Further testing is planned at other locations but the North Coast's Splendour in the Grass is unlikely to participate for the foreseeable future.

On a more sobering note, we report the recent study of voluntary blood alcohol testing at North Coast music events (page 29) by local researchers from the UCRH and Western Sydney University. The study showed that if a subject's blood alcohol concentration (BAC) was high, they were more likely to delay their time of departure from the concert venue. Knowing your status and sharing that knowledge with others led to making better decisions and safer behaviour.

BluesFest now has a global reputation and regularly headlines international stars and legends of the various genres. On page 35, Rachel Guest reflects on the difference between BluesFest and other music festivals around the world. BluesFest attendees are older but probably more hard core. Hard core about the music, not the booze and partying, that is.

Our cover story features "Soul Sister", Sheli Nagas, a local singer and guitarist whose music gives a glimpse into her family's life and history. Sheli is descended from the indentured South Sea Islanders who were brought to Australia in the late 1800s to work in the cane fields of eastern Australia. In addition to her music, Sheli has been key in promoting the Australian South Sea Islander (ASSI) group that lobbies and advocates for her community.

Australians have a long history and an international reputation for heavy drinking. This is considered uncouth in many cultures. On page 30 Chris Ingall discusses how fine dining is an art, with the cultured restricting their alcohol consumption to meal times. They probably make their last drink of the night a dry sherry at the end of the meal.

Not all of us are that self controlled. On page 17 Jane Barker reminds us that there is a linear relationship between alcohol and cancer, with the safest level of alcohol consumption being zero. However its deleterious effects extend far beyond cancer and every medical specialty will be aware of the effect alcohol has played in many of their patients' pathology.

Many Americans have used medicinal marijuana for some time for the control of pain, nausea and anxiety and limited clinical trials are underway in Australia. Editor Robin Osborne (page 9) looks at the current interest in Australia for the clinical use of cannabis and other psychotropic drugs. He also touches on the economic opportunities that sanctioned marijuana cultivation creates for the North Coast community.

On 1 January 2018 California legalised marijuana for recreational use and big business has moved in. Drop in at a Green Dot or visit MedMen and receive the full concierge service. You might be interested in a tub of Mary Jane Relieving Cream or perhaps some Marley Natural Hemp Seed Body Salve. While there you can pick up a "CBD treat" for the dog. On page 13 we get a peek at the current scene in Los Angeles and what the future could look like here.

"If exercise could be purchased in a pill, it would be the single most widely prescribed and beneficial medicine in the nation" is the oft quoted statement by American geriatrician, Robert Butler. Combine that with a diet low in sodium and high in potassium, restricted alcohol intake, decreased consumption of saturated fats but increased fruit, vegetables and grains and there would be a radical change in the diseases presenting to Australian GPs.

These recommendations are part of the recent American guidelines for borderline hypertension management as reported on page 7. The NCPHN is supporting this approach by looking for effective ways to increase exercise levels in the community. It mirrors the more general approach to non-drug therapy being promoted by the RACGP.

The College's Handbook of Non-Drug Intervention is compiling the list of non-drug treatments that work. Professor Paul Glasziou of Bond University is using his expertise in Evidence Based Medicine to help sort the wheat from the chaff.

Practices and procedures are constantly evolving in general practice due to changes in government regulations and legislation. Sam Green gives an update to the Certification of Death at Home on page 19 and in the age of the **Notifiable Data Breaches** we also review the GP's ability to share clinical data with all members of the patient's treating team (page 21).

Looking after ourselves and our young colleagues is now recognised as an important duty for the profession. Young doctors Marissa Baker and David Glendenning give their reports (page 27) on the new Women and Men in Medicine groups that met for the first time earlier this year.

The NoRDocs Facebook group is another new medical organisation on the North Coast. It was formed late last year and is holding its inaugural face-to-face meeting on 30 June. The group comprises medical practitioners living and working in the

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Editorial

by Dr David Guest

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Northern NSW LHD footprint and has grown to over 140 members in six months. It is open to general practitioners, specialists and doctors in training. It provides a forum to discuss any matters of concern but has a particular focus on North Coast health problems and solutions.

The meeting on 30 June follows the same philosophy as the Facebook group. As such it is experimenting with the "Unconference" format where the floor is open to anyone who wishes to speak. However, there are only a limited number of slots available on the Saturday afternoon and these are assigned ahead of time. The outline for the day (page 22) gives further details. It will be interesting to see if this format is useful for furthering health solutions on the North Coast.

It feels good to feel good. That's true irrespective of whether it comes from alcohol or drugs, music or art, religion organised or disorganised, exercise or simply by trying to make a difference in your community. However, as medical practitioners it is incumbent upon us to help our patients consider the consequences and choose wisely. Good now may not be good tomorrow.

GP elected to head AMA

A Melbourne GP has been elected as federal President of the Australian Medical Association, in a decision announced at the end of May.

The new President is Dr Tony Bartone, a former President of AMA Victoria and the immediate past Vice President of the Federal AM. He replaces Dr Michael Gannon whose two-year term has come to an end.

Addressing delegates at the AMA national conference in Canberra, Dr Bartone said the dedication and care that his family GP showed to his father during a serious health crisis had inspired him to pursue a vocation in medicine.

"I now want to fight for Australia's doctors so that they can continue to deliver the same quality health care that my father received," he added.

Dr Bartone said public hospital waiting lists were growing and health insurance "slipping further out of reach"

He continued, "Our health minister [Greg Hunt] needs to understand that the time for rhetoric is over, our patience is wearing thin, we need to see crucial positive actions now.

"Australians have a right to quality health care, and it is up to us - as the AMA - to defend our world class health system... General practice has been systematically starved of funding, putting at risk its very survival.

"We need to see real action now. We will have a Federal Election in the next year, and I am ready for any early election call."

Brisbane-based thoracic physician Dr Chris Zappala was elected AMA Vice President.

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‘Sugar-slave’ sister sings out

by Robin Osborne

Dubbed ‘Soul Sista’ by regulars at the Winsome soup kitchen, where she played piano and sang for six months after moving to Lismore in 2013, Sheli Nagas is a fourth generation of the South Sea Islander people ‘blackbirded’ from the Pacific to work in Australian sugar plantations in the late 19th century.

Sheli’s forebears came from the island of Tanna in Vanuatu and were among the few - estimates suggest around 2500 - who avoided deportation when it was decided their labour was no longer needed. In all around 62,000 islanders were tricked or kidnapped onto company ships and brought to northern NSW and Queensland to cut cane for miserable wages.

Sheli grew up in Bundaberg, the heart of sugar country.

“We were sugar-slaves,” Sheli says, without bitterness but keenly aware of her people’s terrible history.

Sheli Nagas with her new CD in front of a painting in Lismore Regional Gallery by Bundjalung artist, Michael Philp.

She fondly remembers her parents, Rev. ‘Tiger’ Gordon, a cane cutter himself, although long after the slave era ended, and a fine Rugby League player, hence his nickname. A cousin is former Canberra Raiders star Kenny Nagas.

Later her dad became a Christian pastor, working across a range of congregations, many focused on Indigenous communities. Her mum was known as ‘Dixie’, a moniker she got from American troops, from the name of the field mess tin.

“Music was always central to our family life, my dad could play anything - guitar, banjo, trumpet... he was the B.B. King of Australia, he made the guitar dance! Gospel music was very much a part of my upbringing.”

Church was central to the family’s life as the kids were growing up in Bundaberg, the heart of sugar country, and Sheli still goes to church when she can. Of the many stories that stand out from her childhood is sitting on the knee of Aunty Ceil Brown at the age of three.

“It’s a long time ago, but I remember it clearly. Aunty had this lovely voice, and she burst into song with the famous hymn ‘When I Survey the Wondrous Cross’.

“Can you believe that at the age of 18 I would be singing that hymn as part of a choir on the steps of the Sydney Opera House!”

As we sip coffee in the grounds of Lismore cultural precinct Sheli begins to sing the hymn, her voice clear and beautiful, even operatic, which comes as a surprise after listening to her new 8-track CD Sailing Away. The title could be, but isn’t, a tribute to those South Sea Islanders who were taken off by ship to a distant and unknown land.

The album features Sheli’s vocals and guitar work, its jazz-infused feel reminiscent of, say, Nina Simone, with the mostly original lyrics speaking of family, her own not-always-easy life, and, in ‘The night that Debbie came;’ the impact of the 2017 Lismore flood.

To go with her beautiful voice Sheli has an engaging presence, and this charisma is matched by her passion for enhancing the profile of the Australian South Sea Islander (ASSI) community.

Due in no small part to her efforts, a national association has been formed, the federal government has recognised ASSI people as having a distinct identity, and closer links are being made between ASSI descendants and Aboriginal and Torres Strait Islander people with whom inter-marriage has been relatively common over the years.

One aspect of this story is the situation of people of Aboriginal heritage living in Vanuatu.

Hundreds of South Sea Islanders in the Pacific nation say they are being discriminated against because they have Aboriginal ¬ancestry, and say they want official Australian recognition. These people are seen as related to the tens of thousands of sugar-slaves who were forcibly repatriated to the islands at the start of the 20th century.

This is another aspect of how the ‘blackbirding’ scandal was written out of Australian history.

When asked to name her favourite things, Sheli mentions living in the Northern Rivers, which she loves, and music. Anything else?

“Yes, football... walking in the footsteps of my dad, and of course cousin Kenny... I’m a League nut, and used to play in a women’s team up in Bundy... maybe getting a bit old for it now though!”

While a very youthful 54, Sheli may have a point, but then her music is more than enough to score points.

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Jeepers, creepers, where did you get those sneakers?

"Diagnosis creep" conjures up an image of a final year medical student on the far end of the spectrum, sounding a bit like cousin "bracket creep", much beloved by economists and politicians alike.

In November 2017 the American College of Cardiology and the American Heart Association took over from the National Heart, Lung, and Blood Institute and issued new guidelines that changed the classification of hypertension.

For 14 years the previous guidelines had recommended a target of less than 140/90. The new recommendations define stage 1 hypertension as a systolic of 130-139 or diastolic of 80-89. As a result of this some 46% of the USA adult population can be found to have high blood pressure. For the under 45s this will triple the number of males and double the number of females diagnosed with hypertension. The good news is that few of these new patients will be recommended for drug treatment.

A diet low in sodium and high in potassium, along with regular exercise and restricting alcohol intake to less than two drinks per day for males and one for females results in a 4-5 mm Hg lower reading. Going the "whole hog" with decreased saturated fats and increased fruit, vegetables and grains gets an 11 mm Hg reduction.

Such an approach may seem fanciful to an older generation of patients and their doctors but is increasingly seen as both doable and desirable amongst millennials.

The North Coast Primary Health Network has set the local health community a challenge: design and implement a model that works for improving exercise levels in the community. On Saturday 12 May, Professor Paul Glasziou came to the North Coast to advise on this challenge. Professor Glasziou has a long established international reputation in the evaluation of Evidence Based Medicine. The PHN hopes to use his expertise to find a program that works, is acceptable to patients and is affordable to the funders.

The new BP guidelines also place greater emphasis on patient home blood pressure monitoring, but recommend the accuracy of the device is validated.

The guidelines note that more than one medication is often required and that pills containing a combination of drugs improve patient compliance. They also recommend that psychosocial stress, which is correlated to socioeconomic status, be evaluated.

For patients in the lower BP range, medication is only indicated if the patient has a raised cardiovascular risk on one of the many tools available.

Elderly patients with high systolic and low diastolic also benefit from a lower BP. The task is to lower the systolic reading without causing postural hypotension and precipitating the associated risk of falls and fractures. While difficult to achieve, improvements in control can be made through careful monitoring.

Masked hypertension where the blood pressure is normal in the surgery but high at home would seem as rare as hen's teeth to the average GP. However, it is a significant problem and, perhaps unsurprisingly, carries the same risk as sustained hypertension.

Conversely, patients with "white coat hypertension", where the readings are normal outside the surgery carries no increased risk.

The new BP recommendations have been criticised by Australian reviewers, Bell, Doust and Glasziou. They are concerned that the new definition increases anxiety and depression in patients by being labelled as having a disease. They also note a hypertension diagnosis makes it more difficult to get affordable health insurance in societies that do not have universal health coverage, such as America.

Their main concerns, however, are the increased cost and potential side effects of drugs in treating mild forms of hypertension. This is understandable and it will be hard not to think of "medication creep" the next time the cardiovascular drug rep visits.

Image courtesy Josiah Mackenzie cc-by-sa 2.0

Leading change and driving profit

At one stage or another all businesses will have to go through a significant change.

Change is necessary for growth but accepting the need for change can be difficult for some.

Change can arise in various ways, i.e., struggling to find quality employees, a demand to change direction, targeting a new target market and so on. Whether it is an internal or external force driving the change; it is important to lead change confidently.

Here are three ways to lead change with ease:

1. Articulate a clear vision ✓

A strong strategic vision acts as a blueprint for leading change and can provide employees with more clarity about the positive impacts change will have for them and the overall business. A vision statement helps to align your team around the business' goals and prompts them to work towards making the change happen. A clear vision also helps to overcome cultural resistance to change as employees can link the change to positive transformation.

2. Engage with staff ✓

Staff will either accelerate or hinder the change process, so it is crucial to get them onboard and constantly keep them informed. Frequent communication is ideal during times of change. Set aside time for questions and have an open door policy for staff to ask questions. Make a plan, communicate it to staff and check in regularly to assess whether tactics are successful or require adjustment.

3. Celebrate wins ✓

Wins are proof that change is generating results. Celebrating wins reinforces the notion that change is essential for business growth. Celebrating both small and large wins hones in on the collective contribution of the team's efforts and motivates employees to work towards goals which will promote change throughout the business.

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Can recreational drugs be therapeutic?

by Robin Osborne

Call it what you will – names include grass, ganja, hootch, loco weed, whacky tabacky, Mary Jane or her cousin, Alice B Toklas – cannabis has never been regarded by the mainstream as anything but a recreational drug... until now.

Suddenly in Australia marijuana (another of its names) has been moving into the therapeutic 'space', sanctioned by government as suitable for prescribing as an aid to alleviating, although not curing, a range of conditions, some of them paediatric.

Protest at Nimbin Mardigrass, photo dated 2008 by Mombas2 Peter Terry [CC BY-SA 3.0 from Wikimedia Commons]

While prescribing cannabis has so far been limited to, and taken up by, a relatively small number of practitioners, it is well and truly on the radar. In fact some patients, frustrated by legal delays, are buying their own supply, either on the street or online, even on the 'Dark Web'.

So acceptable has the notion of medicinal cannabis become in the Northern Rivers, long considered the nation's cannabis capital, that our National Party MPs, federal and state, are putting their weight and significant government funding behind a proposed cannabis facility.

As previously reported in GP Speak (**Summer 2017-18** and **Autumn 2018**) this growing and processing facility, the beneficiary of a $2.5M federal grant, will be based not in notorious Nimbin but in conservative Casino where beef, not bud, has long been king.

Many analysts, not least a recent **ABC 'Four Corners' program, suggest that the move to legalise medicinal cannabis** is a Trojan horse masking the full legalisation of 'dope' throughout the land. Indeed, the company that aims to establish the Casino facility makes no bones about its longer-term aim.

"Assuming recreational cannabis becomes legal [as it has in various US states] it is suggested that the cannabis market in Australia could grow to $9B over the next 7 years."

If that happens, the head-scratching by doctors asked to prescribe may be over: patients will be able to self-medicate at their corner pot shop.

So that's cannabis, seen from the 1960s onwards as the mood-altering drug of choice for the 'Woodstock generation' of post-WW2 baby boomers. But what of the stronger psychedelics, the mescalins, LSDs, magic mushrooms et al that could take people out of themselves - or into, if you like - on 'trips' that lasted not a few hours but all night and into the next day.

Drug experiences that made you, like it or not, see melting walls, pink elephants, flashes back or forwards, experiences occurring nowhere except in your own mind...

In the words of **cult icon Timothy Leary**, 'turning on' with hallucinogens was the pathway to 'tuning in' and 'dropping out', this suggestion being the obvious fly in the ointment (Leary held a psychology PhD and taught at Harvard). Tuning in is what LSD is being increasingly valued for.

Not surprisingly, a drug that was being studied for its therapeutic effects on alcoholism, depression, and other conditions was quickly branded as 'recreational', apparently a bad thing, and banned.

However, the wheel has now turned, and rapidly, even though public discussion in Australia remains in its infancy. In the USA and UK, notably, the use, and usefulness, of mind and mood altering drugs is receiving close attention, with a thumbs-up consensus starting to emerge.

The New Yorker is one outlet giving considerable space to this work, notably **the role of hallucinogenic drugs in helping terminally ill cancer patients** cope with the fear of death.

Other articles have discussed the difference between a recreational psychedelic journey and a therapeutic one, one writer noting, "Whereas we don't typically trust the insights we have when we're drunk or dreaming, patients who take hallucinogens report having "a sturdy, authoritative experience."

The New York Times wrote that, "In the last few years, calls for marijuana **to be researched as a medical therapy** have increased. It **may be time for us to consider the same for psychedelic drugs**"

Back in 2015 the Independent (UK) reported **two studies** in the Journal of Psychopharmacology showing that a single dose of psilocybin – a powerful, naturally occurring psychedelic compound found in "magic mushrooms" – can radically improve the well-being and positivity of terminally ill cancer patients.

The research, completed at NYU and Johns Hopkins University, looked at participants diagnosed with advanced cancer who undertook 'psychedelic assisted psychotherapy', which entails a moderate to high dose of psilocybin in a controlled environment with psychological support from highly qualified guides.

Results demonstrated immediate and marked reductions in their levels of anxiety and depression that, remarkably, still persisted six months later in 80 per cent of the participants. Researchers compared

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Recreational drugs for therapy?

cont from P9

and contrasted - favourably - this to other treatments such as anti-depressants and counselling, which can take a long time to show benefit for countering isolation, depression and anxiety, and sometimes not at all.

These patients are not dropping out, but dropping back in.

In the USA the potential therapeutic value of MDMA ('ecstasy') is being studied, with interest in the findings coming from, amongst other quarters, Australia, from where Dr Gillinder Bedi, head of Substance Use Research at Orygen, the National Centre of Excellence in Youth Mental Health in Melbourne, has contributed to JAMA Psychiatry a paper titled "**Is Psychiatry Ready for MDMA the Medicine?**"

In **an interview on ABC Radio's Health Report/Life Matters**, Dr Bedi said there were two rationales for using MDMA as an adjunct to psychotherapy: "The broader rationale is that these kind of feelings [loving, playful, open] of reducing your defences interpersonally may act as a kind of fast-track for the therapeutic bond... in terms of PTSD... the rationale is around this reduction of fear."

However, Dr Bedi stressed that, "I have seen no evidence that the drug alone does anything particularly beneficial. So I would not encourage people to rush out and give themselves MDMA to treat anything at all."

While it seems unlikely that the corner pot-shops of the future will also be stocking LSD and MDMA, it is clear that substances once branded as recreational, and consequently outlawed, will increasingly be investigated for their therapeutic potential. To what extent this research will be compromised, or at best delayed, by associated stigma remains to be seen.

Clearly, Australia has been dragging the chain, largely, it may be argued, because of our lawmakers. As Dr Bedi noted, "In the States particularly but also in the UK there is more of a capacity and an understanding of why we would want to give drugs of abuse to humans in controlled settings. And so there have been no clinical trials approved in Australia yet."

As evidenced by National Party MPs putting their weight behind a cannabis enterprise, the times are definitely a'changing. How clinicians, governments, Big Pharma and patients themselves react to the changes will be fascinating to observe.

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California greening is becoming a reality*

by Rachel Guest

In early January 2018, licensed cannabis retailers opened their doors for recreational sales in California and not surprisingly business boomed. Dispensaries previously selling cannabis for medical use only have expanded to include recreational sales and are **reporting record breaking profits**. A veritable crop of new players have entered, and there is even a **new bill** in front of the California Senate that would allow marijuana companies to deliver their products to your door - think Uber Eats but for cannabis.

As an Australian living and working in Los Angeles from 2014 to 2018, it was fascinating to witness Californians' relationship, consumption and broader cultural attitudes toward cannabis. In comparison to more conservative Australian sensibilities, recreational marijuana use was far from frowned upon and in some cases seen as a more sophisticated and even "healthier" alternative to drinking, or at least to being drunk.

It was not uncommon for people to step outside for a casual joint at Friday Happy Hour, work functions, or Sunday football. Equally, many people openly shared the details of their personal habits, drove a vehicle after smoking, and shared tips for getting a medical card. From the workplace to weddings, there appeared to be a very relaxed attitude toward casual cannabis use and this was all before **Proposition 64** had passed.

The legalisation of cannabis in California and other US States is being closely observed by many and the jury is still out on its benefits. As a non-smoker and resident of Los Angeles during the transition from illegal to legal use, I was interested in whether this shift was changing existing consumption and/or encouraging non-users to take up cannabis use. So I sat down with a number of peers who openly smoked.

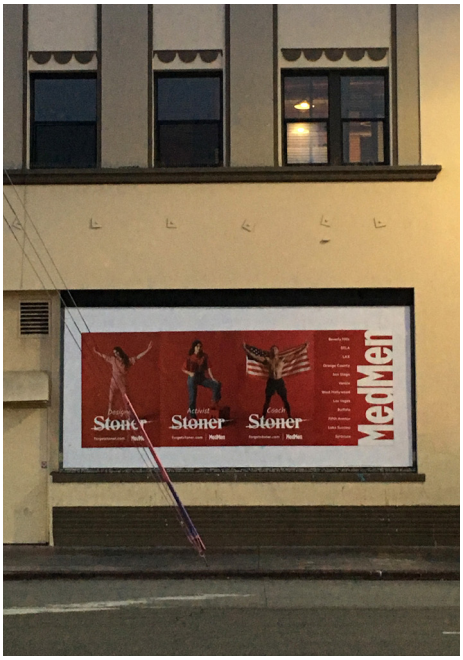
*"**MedMen** do not run pot shops [but] manage class-leading retail stores that happen to sell marijuana and marijuana products."*

Anecdotally, it seemed that regular

cannabis users, i.e. those who smoked most days and owned a medical card before legalisation, generally reported no change in their behaviour. One such smoker explained,www"I have a medical card and have been going to my local dispensary for more than three years. A new neighborhood retail shop has also opened up down the road but to me it's overpriced. You're being charged more for designer branding rather than better quality and that's not important to me."

Most casual to regular male smokers echoed a similar sentiment.

Females, both casual and regular users,



MedMen advertising board

shared a very different story.

If anything, the designer branding was a major drawcard for millennial women and with many cannabis retailers investing in **high end graphic designers** to package their products, it's not surprising. Plus, there's the marketing. **Reality TV star Stassi Shroeder**, a self-confessed "weed newbie" regularly posts Instagram stories of her favorite branded weed pens to her 1.3 million fans, often commenting on the aesthetic of the pen and packaging as much as the quality of the product.

Another trend since the legalization has been in the products themselves. Dispensaries have diversified their offering from different strains of cannabis and pre-rolled joints to include a host of new items.

Leafly, one of the most comprehensive online stores, offer topicals such as oral sprays, transdermal patches, lipsticks and body butters as well as an extensive range of edibles including pop tarts, gourmet gelatos, and even cannabidiol (CBD) infused frozen beef dinners.

A quick scroll to the bottom of their e-commerce platform and you'll also find a line of "CBD pet treats and tinctures formulated exclusively for cats and dogs". As curious as a stoned cat, I asked around to see if anyone was branching out and trying any of these new formulations. Again, it appeared it was the females newer to the market that were most open to "experimenting" with different strains and formats to see what worked best for them.

The final observation between pre and post-legalization are the dispensaries themselves. Even as an outsider, the changes in the buildings' friendliness and accessibility was obvious. Gone were the

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California greening

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dilapidated buildings with blacked out windows that dotted the shadier parts of the Venice Beach boardwalk. Almost overnight, a host or premium retail spaces seemed to crop up across the city from Beverly Hills to West Hollywood to LAX Airport.

One of the largest retail players has to be **MedMen** that label themselves as "redefining cannabis" specifically asserting, "we do not run pot shops, we manage class-leading retail stores that happen to sell marijuana and marijuana products."

The organization's aim to reposition themselves as a retail giant is clear from their careers page, with opportunities including Vice President of Creative Marketing, Retail Architect Designer, Data Analysts and Digital Content Specialists. As a non-Californian resident, I was unable to venture into my local MedMen but one peer described the experience akin to "walking into an Apple store that sells cannabis products. You're greeted by a concierge, everything is presented immaculately under glass display cabinets, the staff is warm, clean-cut and approachable, they even got gift bags."

Another stated the new dispensaries overcame her reservations of having to jump through hoops to get a medical ID or go to dodgier parts of town to purchase her own supply: "The accessibility and invitingness of the spaces make me feel safer both in terms of buying and smoking. It's definitely increased my usage and yes, I'm spending more on average than before."

Only time will tell if the legalization of recreational marijuana use will benefit the physical and mental health of Californian residents. The State's financial health, however, seems to be thriving.

*With apologies to **The Mamas & the Papas** ("Creeque Alley", 1967)

Surgeon takes the long way home

by Robin Osborne

It has taken Gratian ("gray-sh'n") Punch more than two decades to return to Alstonville, the plateau village between Ballina and Lismore, where he was raised. He now lives less than a kilometer from his old family home, and on weekends, out cycling with his wife and young son, is likely to run across his mother.

If this sounds like he's led a sheltered life, think again ... after moving from Lismore's Trinity Catholic College to a boarding school in Sydney (St Ignatius, Riverview) he entered the University of Sydney, completing degrees in Medical Science (First Class Honours) and Medicine before undertaking specialty training in general surgery, incorporating invasive training across all disciplines.

There were, however, unexpected diversions along the way.

While a med student in Sydney he took an after-hours job as a security guard at the legendary Capitol Theatre, seeing lots of top-notch shows. The last he attended was Chicago, which he remembers fondly.

"On that night there was an Army recruitment van outside, and out of curiosity I went over. They said if I joined the Reserve I'd get paid $2000 for a six-week stint, and be fed," he recalls.

"I was hooked."

Dr Gratian Punch

Dr Punch would serve from 2001-2009, not as a medico but in the tactical management of 70 Reservists at Wollongong-based Bravo Company. In 2004 he was awarded Officer of the Year 4th/3rd Battalion, Royal NSW Regiment, and two years later received the Australian Defence Medal.

More military service was to come, this time overseas.

From Feb-Aug 2007, as a Lieutenant (later Captain) Infantry Platoon Commander he was deployed to the Solomon Islands as part of the RAMSI peacekeeping mission - "fortunately we saw no shots fired in anger, at least from our side" - and gained the Australian Service Medal with Clasp Solomon Islands.

He agrees that Alstonville is "gloriously quiet" by comparison.

Having a young family and a busy working life has curtailed his sporting interests - mainly rugby and cricket ("To be a Punch and not play cricket would have had you excommunicated'") but still cycles when possible, although he is aware of the dangers on our roads. Mostly he sticks to the stationary version.

Professionally he has various passions, not least hepatic ("As we know, there's a high burden of hepatitis in the area"), pancreatic and biliary surgery, and is impressed by the advances in this field over recent years: "There's a lot we can now do here in Lismore, rather than referring patients away."

Bariatric surgery is another specialty, a shared interest with Dr Candice Silverman who works out of the Tweed Hospital and John Flynn Medical Centre. Procedurally and post-operatively the pair 'share' patients.

Delighted to have returned to his roots, Dr Punch works from Dr Austin Curtin's rooms at St Vincent's Private Hospital, having done a locum for the highly respected surgeon, now moving to retirement, when he was deployed to Iraq with the Army - in his case with the Medical Corps, not the Infantry.

Dr Gratian Punch is working as a general surgeon across public hospitals in the Richmond Valley and at St Vincent's Private Hospital.

About the 2018 Influenza vaccination

Vaccination remains our best defence against seasonal influenza, which causes significant morbidity and mortality in the Australian community each year. You, as a vaccination provider, play a key role in informing the community about risks associated with influenza and of the importance of influenza vaccination.

-Professor Brendan Murphy, Australian Government Chief Medical Officer

by Marianne Trent

A greater number of vaccine types and brands are now being distributed to Australian practices, with age restrictions applying to all registered vaccine brands.

This year there are influenza vaccines of differing valency:

• **Quadrivalent vaccines** – two strains of influenza A (H1N1/Michigan & H3N2/Singapore and two strains of influenza B (Phuket and Brisbane).

• **Trivalent vaccines** – two strains of influenza A (H1N1/Michigan & H3N2/Singapore and one strain of influenza B (Phuket).

The Australian Technical Advisory Group on Immunisation (ATAGI) has released its statement on seasonal influenza vaccines for 2018.

Vaccines for children (6-35 months)

Children in this group should receive the quadrivalent FluQuadri Junior. Do not use a half dose of any other flu vaccine.

Vaccines for children & adolescents (36 months to 17 years)

Children in this group should receive FluQuadri or Fluarix Tetra. Both of these are quadrivalent vaccines.

If the child is aged 6 months to < 9 years of age and it is the first time they have had a flu vaccine, they should receive two doses, one month apart. In subsequent years they require one annual dose only.

All children aged 6 months to less than 5 years are entitled to free flu vaccines in NSW. Any child aged 5 or more years who has a medical condition which predisposes them to severe influenza is also eligible for free flu vaccine

Vaccines for adults aged 18-64 years

The following quadrivalent vaccines can be given to adults aged 18-64: FluQuadri, Fluarix Tetra, Afluria Quad.

Any adult who has a medical condition which predisposes them to severe influenza is also eligible for free flu vaccine.

Vaccines for adults aged 65 years and older

This year two new trivalent vaccines for persons over the age of 65 have become available.

Fluzone High-Dose contains four times the haemagglutinin of the standard dose.

Fluad contains an adjuvant MF59 which boosts the action of the vaccine.

Trials in the US and Canada have found that these vaccines are between 22%-24% more effective in older persons than the present quadrivalent vaccines. Your patient will only require a vaccination of one of these vaccines, not both.

Latex in vaccines

In 2018, the following influenza vaccines do not contain latex: FluQuadri™ Junior; Fluquadri™; Afluria Quad® and Fluzone High Dose®.

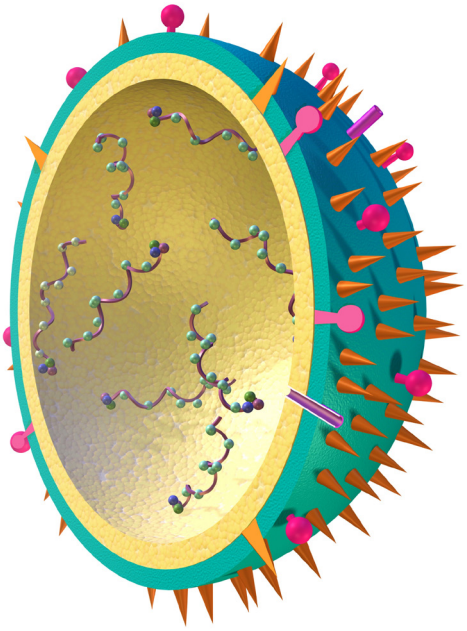
The following influenza vaccines do contain latex in the removable needle shield: Fluarix Tetra® and Fluad®.

FAQs

Q. What should I do if a patient over 65 receives a quadrivalent vaccine from the local pharmacy?

A. A second dose of flu vaccine is not recommended but is not contraindicated.

Q. Should I use Fluzone High-Dose or Fluad for patients younger than 65 if they have severe chronic disease?



3-D illustration of a flu virus - Courtesy National Institutes of Health (NIH)

A. No, these two vaccines are only registered for persons over the age of 65.

Q. My patient has an egg allergy. Can s/he still be vaccinated?

A. You need to ascertain what the allergic reaction is. If they can eat food containing eggs such as cakes, they do not have anaphylaxis to egg. If you need further advice regarding this call the Immunisation Specialist Clinic at Westmead. 1800 679 477.

Q. Can flu vaccine be given at the same time as other vaccines?

A. All inactivated influenza vaccines can be administered concurrently with any other vaccine, including pneumococcal polysaccharide vaccine, zoster vaccine and all scheduled childhood vaccines.

Parents/carers of infants or children who are recommended to receive both influenza vaccine and 13-valent pneumococcal conjugate vaccine (13vPCV) should be advised of a possible small increased risk of fever following concomitant administration of these vaccines.

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

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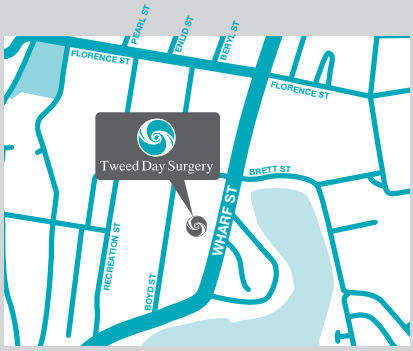

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Alcohol – a healthy pleasure or a menace to health?

*First published by Dr Jane Barker on website **'To Medicine with Love'**.*

This article is written in response to a recent report on Alcohol and Cancer published by the American Society of Clinical Oncology and asks whether we, as physicians, have difficulty talking honestly about alcohol with our patients, because of our own attitudes towards it.

It is not unimaginable that bottles of Château Mouton Rothschild, which once bore the artwork of Salvador Dali and Pablo Picasso, might one day be required to have plain packaging and images of oesophageal cancer or a cirrhotic liver. (1)

So concludes a lead article in a recent edition of the Lancet, reporting on a newly published statement on alcohol and cancer from the American Society of Clinical Oncologists or ASCO. (2)

Alcohol and cancer

In 2012, it was estimated that 5.5% of all new cancers and 5.8% of cancer deaths worldwide were attributable to alcohol (3) and yet the contribution of alcohol to cancer has been generally underestimated by the medical world.

The ASCO publication reviews and summarises current research, and makes recommendations for prevention. Alcohol is causally associated with oropharyngeal and larynx cancer, oesophageal cancer, hepatocellular carcinoma, breast cancer, and colon cancer. Even modest use of alcohol may increase cancer risk, but the greatest risks are observed with heavy, long-term use. The associations between alcohol drinking and cancer risk have been observed consistently regardless of the specific type of alcoholic beverage. The strongest associations were observed for upper aero-digestive tract cancers (i.e. larynx, oesophagus, and oral cavity/pharynx), which involve tissues that come into direct contact with ingested alcohol. As well as being a causative agent, alcohol may affect response to treatment and rates of recurrence. (2)

World Cancer Research Fund/AICR made the following recommendation: "If alcoholic drinks are consumed, limit consumption to two drinks a day for men and one drink a day for women." They also recommend that, "for cancer prevention, it's best not to drink alcohol." (4)

Risks of harmful use of alcohol

Approximately 3.3 million deaths worldwide result from the harmful use of alcohol each year. (5)

In the UK in 1999, liver disease surpassed lung cancer and breast cancer as the leading cause of years of working life lost and it is estimated that in 2-3 years, liver disease will overtake ischaemic heart disease in this regard. (6) While the epidemiological factors implicated in severe liver disease are multifactorial, including hepatitis, alcohol remains the major modifiable risk factor.

The Australian Institute of Health and Welfare reported that in 2011, alcohol was responsible for:

- 28% of the burden due to road traffic injuries
- 24% of the burden due to chronic liver disease
- 23% of the burden due to suicide and self-inflicted injuries
- 19% of the burden due to stroke. (7)

In 2013, 26% of people a consumed five or more standard drinks on a single drinking occasion at least once a month, and 47% of pregnant women reported consuming alcohol during their pregnancy. Over the previous 12 months, 21% of recent drinkers reported they had put themselves or others at risk of harm while under the influence of alcohol – driving a vehicle, or verbally or physically abusing someone or undertaking some other risky activity.

Not only are those choosing to drink in excess at risk, but in our society, all the people around them are at risk. In 2013, 26% of Australians had been a victim of an alcohol related incident, most commonly verbal abuse. (7)

As the Lancet says: "alcohol is an undeniable menace to health" and goes on to say: "moves towards safer drinking need to be led by health professionals." Routine surveillance, health education, and cancer prevention provide contexts for doing so within any consultation." (1)

Doctors and Alcohol

As a young doctor, I attended a teaching session on the then, ground-breaking surgery for micro-penis. A middle aged female paediatrician stood up and asked why there was all this bother when really sex was overrated. Of course, there were guffaws of laughter. Writing about doctors and alcohol makes me feel like that middle-aged paediatrician.

I learned to drink at medical school, having been a quiet teenager. We used alcohol to socialise, to blot out the unpleasantness of dissecting cadavers in the anatomy lab, to overcome shyness and inhibitions and to have what we thought was a lot of fun. As a young doctor, I enjoyed a drink or two, but gave it up a long time ago. In our hospitals then our doctors' lounge always had a bar for the use of doctors on duty. It was a part of our medical culture. How many of us were delighted to have the "scientific evidence" that alcohol in moderation is cardio-protective, but are less willing to look at its inherent harm?

The ASCO report suggests that lack of clinician knowledge about the risks of alcohol, particularly as a carcinogen, prevents physicians delivering effective preventative care and that in fact many doctors do not routinely ask about alcohol use at all. (2) It is easy to say "don't smoke" when you do not smoke yourself, to discuss the dangers of obesity when you are a super-fit cyclist, but how do we feel when we talk about alcohol?

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Alcohol and health

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A GP friend of mine who has been diagnosed with both diabetes and hypertension explained how both of his specialists had recommended he has no more than 2 standard glasses of red a night, and went on to joke how he now dutifully drank 2 for the cardiologist and 2 for the endocrinologist!

Is it possible that as a profession we have been unwilling to honestly look at the effects of alcohol on health? Could this be because as a profession it has been our own "drug of choice"?

The Australian Beyond Blue study (8) reported on the mental health of doctors. Self-reporting (always at risk of under-reporting) showed that younger doctors had the highest levels of moderate or high-risk alcohol use. Across all ages males had significantly higher levels of moderate or high-risk use compared to females (18.1%, and 10.9%, respectively).

The ASCO report suggest that just as overweight or obese physicians are less likely to counsel their patients about obesity, alcohol use among physicians may make them less likely to counsel patients about the risks of alcohol use. (2)

In Australia, our society was weaned on alcohol. In the early days of colonisation rum was used as currency – people were paid for their labour with alcohol. In a somewhat deluded attempt to curb drunkenness, breweries were built to introduce beer and later vineyards planted in the sole attempt to curb the drinking of spirits.

Alcohol is an integral part of our social gatherings and celebrations; any change will be a slow change but our relative success with reducing smoking suggests it is not impossible. Alcohol is widely used and accepted in moderation, but we see the results of over-use of alcohol not only in disease but in the carnage of traffic accidents, domestic violence and assaults. Those working in emergency settings are all too familiar with this and are often themselves put at risk.

Both the ASCO report and the Lancet editorial ask that as clinicians, we start to talk with our patients about the broader risks of alcohol use. Perhaps if we were to gently explore why we may have difficulty talking about alcohol and our own relationship with it and if, at the very least, we address harmful and hazardous drinking, in ourselves and in our patients, we could start to turn the tide.

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When someone dies at home

Parkview Funeral Director, Sam Green outlines the requirements of general practitioners to certify death when it occurs at the patient's home. Newer options such as the ***Death Certification Arrangements for Expected Home Death*** *form make the situation easier for all concerned.*

With expanding options of home care and palliative care services we can expect to see more deaths outside our hospitals and aged care facilities.

The latest research shows that 70 per cent of Australians now wish to die at home, surrounded by friends and family. However, only 14% of people are passing away in the comfort of their own home often because advanced care planning has not been put in place. (Source: **Dying Well, Grattan Institute 2014**)

Some of the benefits of dying at home are that it:

• Helps maintain emotional well-being by being cared for in a familiar environment surrounded by people they know well.

• Lets the individual spend more time with family and friends.

• May offer more opportunities to maximise quality of life.

• May feel more natural and less clinical, while still giving access to expert medical advice and symptom control.

• Allows a sense of control over the last part of the person's life.

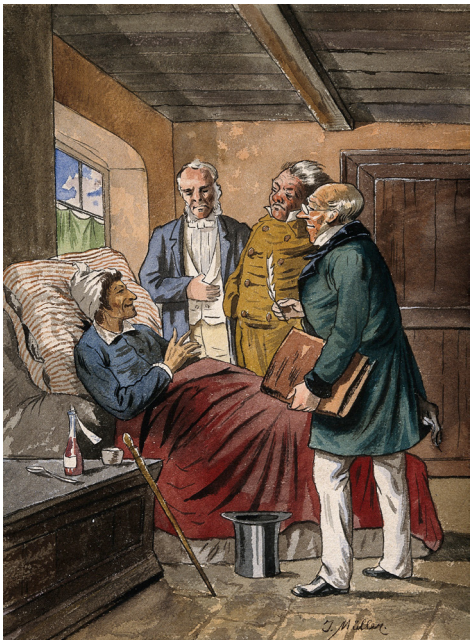
• Family and friends may find comfort in providing most of the care.

If a person chooses to die at home they do need to get their affairs in order. The loved one should discuss their personal preferences with their family and it is suggested that they:

1. Document their wishes in writing.
2. Make a will.
3. Organise a Power of Attorney (PoA), Enduring Power of Attorney (EPoA) and Enduring Guardian.
4. Develop an Advance Care Plan (also known as an Advance Health Directive).

If the death is expected

If you are the person's medical practitioner it is best practice to ensure that the patient has finalised their Advance Care Plan and estate planning (Will and Power of Attorneys).



Wellcome Library, London. A sick man at home in bed discussing his case with three physicians. Watercolour by T. Müller. CC BY 4.0

You also need to be aware of NSW Health Policy Directive, **Death – Verification of Death and Medical Certificate of Cause of Death.**

Verification of Death is a clinical assessment process undertaken to establish that a person has died. Using a standard regime of clinical assessment tools, a registered medical practitioner, registered nurse or qualified paramedic can establish and document that death has occurred. Verification of Death has previously been known as extinction of life in NSW Health policy.

Verification of Death (form SMR010530) is required to enable a person's body to be transported by a funeral director or government contractor. In circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD). A MCCD must be completed within 48 hours of the death. (**Avant Fact Sheet**, **MCCD Order form**)

A medical practitioner should only certify the cause of death if a diagnosis as to the cause of death can be made. If the medical practitioner is unable to ascertain the cause of death then the matter is required to be referred to the Coroner.

Death Certification Arrangements for Expected Home Death

Within regional and rural settings, there may be specific challenges in organising a medical practitioner to complete the Medical Certificate of Cause of Death (MCCD) due to greater distances involved and the limited medical workforce. Local Health Districts may elect to put in place local procedures to designate the medical practitioner responsible for completing the MCCD in advance of an expected death. This approach is encouraged by the State Coroner.

In many cases the patient's GP will head the health care team for patients approaching and reaching the end of their lives who choose to be cared for and die at home. To assist with formalising this process, a Death Certification Arrangements for Expected Home Death form (SMR010.531) has been developed and endorsed by NSW Health. Use of this form is encouraged, but not mandated where Local Health Districts have elected to develop a process for managing expected deaths in this way. It has been enabled on the North Coast.

Once the death has occurred at home

The family/friend/carer/nurse of the deceased need to notify the deceased's medical practitioner without delay. The medical practitioner will advise if they are able to complete the Medical Certificate Cause of Death (MCCD).

The Medical Practitioner may have already completed a Death Certification Arrangements for Expected Home Death form, which will be with the deceased, or

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The ins and outs of My Health Record

It seems a simple message – should one continue to have a My Health Record, which will soon apply to every Australian, or choose to opt out, a decision that must be made between 16 July and 15 October this year?

Announcing the option, backed by state and territory governments and key professional bodies, including the RACGP, the federal government issued a 1500-word **media release** - around four pages - appended by a footnote about the Australian Digital Health Agency (mission: Safe, Seamless, and Secure: evolving health and care to meet the needs of modern Australia).

Apparently the message is deceptively complicated, however, because many people appear to have little idea of what the MHR actually is, even though five million already have one.

In the words of Health Minister Greg Hunt, "My Health Record enables important health information including allergies, medical conditions, treatments, medicines, and test reports to be securely shared between clinicians and their patients.

"It also enables people to take more control of their own health and wellbeing, manage their children's health, and upload key documents, like advanced care directives.

"My Health Record provides many benefits to patients, including reduced duplication of tests, better coordination of care for people with chronic and complex conditions, and better informed treatment decisions".

As the message has been clearly under-sold to date a national communications strategy, supported by peak bodies and the Primary Health Networks, will be rolled out to inform the community of the benefits of digital health, and explain the opt out process.

Individuals who do not want a record will be able to opt out during the three-month window by visiting the My Health Record website or by calling 1800 723 471 for phone based assistance.

Australians can cancel their My Health Record at any time after the end of the opt out period, or choose to create one, if they opted out.

Forms will be provided on request, and additional support will be provided to Aboriginal and Torres Strait Islanders, people from non-English speaking backgrounds, people with limited digital literacy, and those living in rural and remote regions.

Consumers Health Forum (CHF) CEO Leanne Wells welcomed the announcement, calling it "a key step in the shift from health consumers as passive patients, to consumers as active partners in their own care."

AMA President Dr Michael Gannon said, "The current system of medical records means that we may have incomplete information on a patient – especially if the patient has recently seen another specialist or has been discharged from a hospital."

RACGP President Dr Bastian Seidel said, "Most Australians are digitally connected and make everyday use of digital services across a range of industries, so it makes sense that both healthcare providers and their patients have access to digital health services.

"The RACGP is supporting GPs to prepare for the My Health Record opt out process and to make informed decisions about the use of the system in their practice."

Pharmacy Guild of Australia National President George Tambassis said "The Guild is committed to helping build the digital health capabilities of community pharmacies and advance the efficiency, quality, and delivery of healthcare to improve health outcomes for all Australians.

Individuals will be able to ask their healthcare provider not to add specific test reports and other medical information to their MHR. Individuals can also restrict access to specific information in their record by applying a Limited Access Code to that specific document, or by applying a Personal Access Code to the entire record.

Minister Hunt encourages all Australians to use their MHR and to speak with their healthcare providers regarding its benefits.

Dying at home

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alternatively there may be a Verification of Death form completed at the time of death by an attending registered nurse or qualified paramedic.

Once this is completed the family should contact the Funeral Director who will organise the transfer of the body to their mortuary. The Funeral Director will require either the completed (1) MCCD, (2) Verification of Death or (3) Death Certification Arrangements for Expected Home Death form before they can remove the deceased's body.

If the medical practitioner is unable to ascertain the cause of death and is not prepared to complete a Medical Certificate Cause of Death, the family needs to contact the local police without delay. The police will attend the place of death of the deceased, inspect the body and complete a report for the Coroner.

Once the police have completed their initial investigation they will contact the Government Contractor to remove the body and deliver it to the nominated forensic institution for an autopsy in an attempt to ascertain the cause of death. The Coroner will notify the family when the deceased's body can be released to the care of a nominated Funeral Director or delivered to a regional hospital in the area where the person died. Generally, the Coroner will hold the body for up to 7-10 days before release.

A death, whether it is in the hospital, nursing home or hospital is traumatic for all family members. It is important to have completed clear documentation by both the family and the GP so as not add to that burden.

Right information, right person, right time

Optimising patients for surgery is an essential part of good medicine and requires a team approach. In recent years there have been improvements in perioperative iron management as a result of the National Blood Collaborative, in which St Vincent's and Lismore Base took part. The improvement has occurred because of improved co-ordination and communication between the GP, surgeon and the pre-operative clinics.

A difficulty sometimes encountered by the pre-op clinic at LBH is getting current health information on their more frail patients. This information is usually sent to the surgeon by the GP but may not in turn reach the pre-op clinic.

North Coast GPs are increasingly being requested to send down a faxed health summary to various departments at the hospital, most notably pharmacy and the pre-op clinic. While this is not a problem for most, some practices are concerned about the release of this information particularly since the recent enactment of the Mandatory Data Breach Notification legislation.

They see these requests as requiring the written consent of the patient to release this information to a third party and quote the

Image courtesy Weiss Parrz - cc by-sa 2.0 - www.weisspaarz.com

RACGP Standards for General Practices in support of their position.

Some have argued that this as an overly strict interpretation of the intent of the law and the Standards. Section 2.3.1.3b of the RACGP Privacy and Managing Health Information in General Practice paper (May 2017) states:-

"Health information may be used or disclosed for another 'secondary' purpose where the patient would reasonably expect a use or disclosure related to their healthcare."

The Office of the Australian Information Commissioner has specifically addressed the sharing of information with other health providers without consent. It states:-

"The Privacy Act is not intended to impose unnecessary administrative burdens on providers, or to inconvenience patients, by requiring consent every time health information is appropriately shared with another provider, or otherwise handled in the delivery of healthcare. At the same time, the Privacy Act seeks to ensure that individuals retain appropriate control over how their information is handled, including ensuring that it is not handled in ways that an individual would not expect."

Past experience suggests that most patients believe information is readily shared between all members of the medical team. They are often, unpleasantly, surprised when information about a recent medical episode is not available.

It is therefore perfectly acceptable for GPs to release information to the clinics at the hospital when requested and without specific consent but the GP should make sure that they do not send any information that the patient would not wish released and which does not compromise perioperative care.

Good clinical practice requires that all appropriate patient information be readily distributed between all medical members of the treating team. The recent legislation does not negate this in any way.

Rural students' isolation can be addressed

A recently published paper shows that boosting self-efficacy - defined by psychologist Albert Bandura as "one's belief in one's ability to succeed in specific situations or accomplish a task" - can reduce the impact of social isolation experienced by one-third of students undertaking rural placements.

The subjective feeling of social isolation can be defined as a sense of not belonging to a community or geographical area. Studies suggest that perceived social isolation contributes to depressive thoughts and/or distress, and renders medical students less likely to pursue a rural career after graduation.

However, social isolation can be addressed through enhancing the attribute Bandura said plays "a major role in how one approaches goals, tasks, and challenges."

The paper, Self-efficacy reduces the impact of social isolation on medical student's rural career intent, was authored by Vivian Isaac (Flinders Rural Health), Sabrina Winona Pit (University Centre for Rural Health North Coast and Craig S. McLachlan (Rural Clinical School UNSW), and published in **BMC Medical Education BMC series**

"Social isolation in medical students... may influence medical career decision making," the authors noted, based on their investigation of the career intent of 644 medical students attending rural clinical schools.

Having concluded that 31.3% of surveyed students self-reported feeling socially isolated during their rural placement they focused on gauging whether self-efficacy can influence their view on pursuing a career in rural-based medicine.

They found that self-efficacy reflects how students feel they can or cannot be a successful rural medical practitioner, and that the attainment of high levels of rural clinical self-efficacy – "a relatively new construct" - reduces the effects of social isolation.

"Our initial findings could also assist policy makers in developing rural workforce strategies that both identify and reduce subjective social isolation for rural medical students," the researchers said.

"We note that social isolation in one individual can affect other individuals in a group via negative emotions such as loneliness and hence there is benefit to reduce negative outcomes via contagion."

The NoRDocs Unconference

NoRDocs, the Northern Rivers group of doctors that discusses local medical matters on its **FaceBook page**, is holding its first forum on 30 June at **UCRH, Lismore,** opposite Lismore Base Hospital. The forum will run from midday to 5 pm and will be followed by an informal dinner at a local watering hole.

The conference is based on the **Unconference format** where many of the delegates are also the presenters. This format provides the flexibility for participants to present and discuss matters that are of interest to them. These may be small items or short lived issues that would not normally attract the attention of larger medical organisations like Primary Health Networks or Local Hospital Districts.

The format for the afternoon is three concurrent streams with each stream comprised of 8 individual slots lasting 30 minutes. Presentations can vary from a TED Talk style presentation lasting 15 to 20 minutes followed by a discussion for 10 to 5 minutes, to the opposite where a brief outline of a problem can be followed by a 20 minute group discussion. However, all talks finish after 25 minutes to allow the next presenter to set up and for participants to change rooms.

If you have an itch to scratch the unconference format is your venue. NorDocs aims to encourage communication and collaboration and while no topic is off limits the event is the ideal platform for discussion of local medical issues.

As Kaliya Young notes in her **Unconferencing - how to prepare to attend an unconference**, "it's OK if only two people turn up to your talk since you have found the two people who are interested in your topic".

The final session of the day is reserved for **lightning talks**. Presenters have just four minutes to get their message across and session facilitators are traditionally ruthless. It can be a fun one to finish a conference.

The event is open to all staff in medicine including nursing, allied health, medical administrators and practice managers.

Registration is now open through Eventbrite and the $30 fee covers a catered afternoon tea.

The program will be in evolution until just before the conference starts but the **current version** can be found on line. Those wishing to be added to the line up should email **registration@nrgpn.org.au** with their name and topic.

See you there!

Radiation Oncology Specialist at Byron Bay

Professor David Christie (Radiation Oncologist) attends the Byron Bay clinic once every six weeks and has extensive experience in treating all major cancer types including prostate brachytherapy, urological cancer, lymphoma, skin cancer and benign disease.

Dr Steven Stylian (Medical Oncologist) attends the centre every 3 weeks, ensuring a multi-disciplinary approach.

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or email: ccq.reception.tugun@genesiscare.com.au

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Suite 6 / 130 Jonson Street, Byron Bay NSW 2481

Treatment locations:
Southport
Premion Place, 39 White Street, Southport Qld 4215
Ph 07 5552 1400

Tugun
John Flynn Private Hospital, Inland Drive, Tugun Qld 4224
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Genesis Cancer Care Queensland

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An inside view of outsider art

A recent show at Hobart's MONA gallery prompts Dr Andrew Binns to reflect on the influence of 'madness' on art creation.

The linked question of what is art and who is an artist is forever under challenge and this came to the fore in a recently concluded exhibition at Hobart's now-legendary Museum of Old and New Art (MONA). Featuring a collection of nearly 2000 artworks from 200 non-professional artists from around the world, the so-called "Museum of Everything' was first exhibited in London in 2009.

The founder and collector James Brett described it as the world's first wandering institution for the untrained, unintentional, undiscovered and unclassifiable artists of the nineteenth, twentieth and twenty-first centuries, adding that it questioned who can be considered an artist.

'Offering for the King's child' from Series 18: the Countess of Suburbia

While Brett prefers the term 'non-academic art' the notion of works created by outsiders was picked up by art critic Roger Cardinal in 1972 as an English synonym for art brut ("raw art" or "rough art"), derived from French artist Jean Dubuffet in 1945 to describe art created outside the boundaries of official culture. Dubuffet's particular focus was on work done by insane-asylum inmates.

In the late 19th and early 20th century people became fascinated with the "art of the insane". These were times when people with serious mental illness were incarcerated in asylums, and treatments were not only largely ineffective but often harmful. One treatment that was taken seriously was art therapy and many of these people produced art that reflected their mental state and may have given some relief of their suffering.

At this time. with schools such as Dadaism and Surrealism powering, modern art was becoming more abstract. Notable figures such as Paul Klee, Max Ernst and Jean Dubuffet himself gained inspiration from art produced by the mentally ill in asylums.

In 1960s and 1970s the drug company Sandoz (who made the antipsychotic Melleril) produced a series of prints done by people in asylums, calling this "Psychopathology and Pictorial Expression" (images shown from series 18: the Countess of Suburbia). The prints came with a case history written by a psychiatrist, Dr Alfred Bader, who was Medical Superintendent of the Psychiatric Clinic of the University of Lausanne, Switzerland. The company gave the works to psychiatrists all over the world as a promotion for Melleril.

'The Doleful Lion' from Series 18: the Countess of Suburbia

Times and attitudes have changed, and medical treatments for calming and improving the mood of severely disturbed people in asylums have enabled them to live in less institutionalised environments. It is 35 years since the Richmond Report recommended moving people out of psychiatric wards in mental institutions to be cared for in the community. The deinstitutionalization process actually began in the 1960s.

Today outsider art can now encompass almost all aspects of naïve and self taught art, while Art Brut still remains at its core. Outsider art has established itself as a vibrant component of the art of our time and continues to have influence on contemporary artists.

Quality works of art can be created by people who have no art training and they can come from all walks of life. The images they create are deeply personal and the result can often be non-verbal communication of the artist's innermost feelings and mood. There is often therapeutic value in creating this work, particularly for those with mental illness. Such work can be discovered in any community and should be valued.

Scam me if you can

by David Guest

In the late 1960s international scammer and impostor, Frank Abagnale, posed as a medical officer in an paediatric hospital in Georgia in the USA. As the senior resident on the night shift he worked in a supervisory role. Getting the junior staff to manage all the cases allowed him to escape detection for 11 months. Most of his medical knowledge was derived from watching Dr Kildare, the popular TV medical drama of the time. Seeking and "running with" the majority opinion proved to be a good tactic. We concur.

Between the ages of 16 and 21 Abagnale is also said to have impersonated a pilot, a prison officer, a university teaching assistant and a lawyer. He traveled around the world getting free accommodation and free flights as a co-pilot hitching a ride in the "jump seat". He clocked up over one million miles and scammed 2.5 million dollars through bank cheque fraud over this six year period.

He was captured in 1969 in Montrichard by French police and served time in prison in France, Sweden and the USA. He escaped from custody twice.

After four years in America prison he agreed, in exchange for his freedom, to work with the FBI on fraud detection.

After serving his time he used his natural talents and wealth of experience to provide fraud detection services to financial institutions around the world through a new company he formed, Abagnale and Associates. He also lectured in fraud detection to FBI agents at their training Academy in Virginia.

He was portrayed by Leonardo diCaprio in the Steven Spielberg movie, Catch Me if You Can, which is loosely based on his autobiography.

Abagnale continue to be an active lecturer and investigator to this day. His work now focuses on cybersecurity and he recently gave this talk at Google. In it he speaks about his life but also comments on fraud in the age of the internet.

Hacking attacks take one of two forms. Flaws found in cryptographic algorithms or their implementation may make many websites and consumer applications vulnerable to compromise. These hackers can use these newfound vulnerabilities for nefarious purposes.

Such criminal hackers are referred to as crackers in traditional computer security circles. However, many talented security professionals now have gainful employment working for the cyberwarfare departments of their homelands.

An equally significant security danger is the cracker who uses social engineering techniques to gain access to computer resources. Crackers trick users into revealing personal data that can then be used to access systems and to escalate their privileges sometimes causing millions of dollars of damage to large companies. Kevin Mitnick and Susan Headley are two of the more colourful characters from the early days of cracking.

How can one minimise the risk of attack from social engineering? Abagnale is bullish on Trusona, the passwordless authentication scheme used by the American security forces and companies around the world. A user logs onto the Trusona app on their mobile phone, authenticating with their fingerprint or other biometric identifier and then using the app they scan a Trusona QR code on the website that they are trying to access.

It does away with usernames and passwords. Instead it follows the recommended security practice of using two different forms of authentication. In Trusona's case they are something you have (your mobile phone) and something you are (your fingerprint).

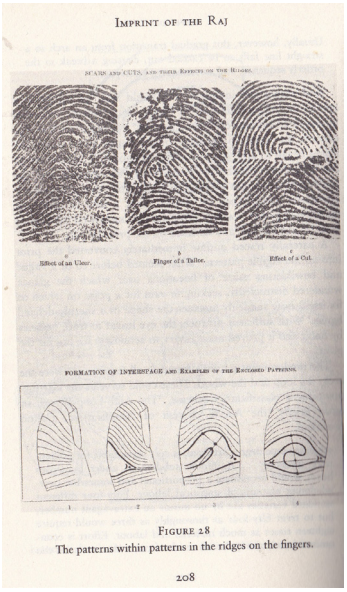
It is far superior cryptographically to most current schemes particularly given the notoriously lax security employed by most end users. Subscribers can be confident in its use since it is endorsed by both the CIA and the world's most famous living scammer.

from 'Catch Me If You Can - Trailer'

Dr Harris, do you concur?
Concur, with what, sir?
With what Dr Ashley just said, do you concur?

THE BIRTH OF FINGERPRINTING

The use of our unique fingerprints has travelled from British-run Bengal in the 19th century to become a security measure in today's smartphones. Before being a standard tool to identify criminals they had been valued as personal signatures - which they have become again. The extraordinary tale is recounted by Chandak Sengoopta, a doctor and psychiatrist, in Imprint of the Raj – How fingerprinting was born in colonial India (Macmillan 2003).



Hospital in the Home (HITH) Service

Dr Richard Lucas outlines the new Hospital in the Home (HITH) Service at Lismore Hospital

What is the HITH service?

HITH is an alternative, patient focused, easy to access, voluntary, cost-neutral model of care for acute and post-acute medical patients to be treated outside the hospital inpatient setting.

The model of service delivery is offered as either "in-centre treatment" where the patient returns to the Lismore Base daily or goes to the relevant community health service for treatment. Alternatively, where possible, the service provides treatment in the patient's home or at the Residential Aged Care Facility (RACF).

Care is provided by appropriately trained registered nurses or a physiotherapist.

The HITH physician also operates clinics at Lismore Base Hospital three times weekly to review patients whose illness requires closer monitoring.

The HITH entry criteria dictate that the patient is an admitted inpatient to LBH.

What are the advantages of hospital patients treated with the HITH service at home?

Patients usually prefer to be treated at home. This is an option if all relevant issues have been reviewed. The aims of the service are explained to the patient and any concerns they have are addressed.

Patients have better health outcomes sooner when treated in their home environment and the HITH service is also more cost-effective than hospital-based inpatient care.

Where is the HITH service located?

The HITH service for Lismore Local Health District is currently located in the Emergency Department at Lismore Base Hospital. The HITH clinic/office is expected to move soon to a larger alternative suite at LBH that can accommodate this new ambulatory care model.

How is the HITH service staffed?

The HITH staff at Lismore Hospital includes five experienced registered nurses, one specialist physician and one physiotherapist.

What geographic area does the Lismore-based HITH team service?

The service covers the Lismore, Casino and Ballina catchment areas.

What clinical conditions are usually managed by the HITH service?

The list of diagnoses commonly treated by our HITH service currently includes:

- skin and soft tissue infections
- lower respiratory infections eg stable pneumonia, bronchiectasis with pseudomonas colonisation
- acute pyelonephritis
- post-operative infections
- joint and bone infections
- endocarditis
- bacteraemia
- venous thrombo-embolic problems transitioning from heparin to warfarin
- type 2 diabetes patients requiring transition to Insulin
- decompensated heart failure and pulmonary hypertension
- hypovolaemia related to diarrhoea, hyperemesis etc
- selected geriatric patients with cardio-respiratory problems and physical deconditioning
- neuromuscular disorders requiring home physiotherapy

This list will expand over time.

Are there any unsuitable patients?

Yes:

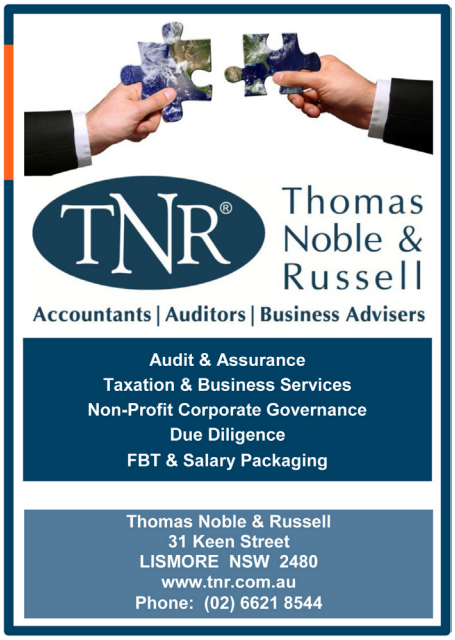
- Patients who live outside the Richmond network, Ballina LGA (excluding Nimbin)
- Aggressive or acutely mentally ill patients
- Patients and carers with a poor understanding of their medical condition
- Active drug and alcohol issues
- Aggressive dogs
- No home telephone or mobile phone

How do I refer a patent directly to HITH?

The working hours for the service are 0800 to 1800 hrs 7 days a week and contact is made through the on ***call HITH Nurse on 0401 711 688.***

Dr Richard Lucas, HITH physician, may also be called on request for specific clinical advice during the office hours 0800 to 1700 hrs Monday to Friday on 0408 897 694.

Further information about HITH is listed in the ***North Coast Health Pathways***



My Time in The Clarence Valley

by Lara Beukes

Medical Student from the University of Wollongong

When I was allocated Grafton by my university I expected my year-long placement to occur in a stereotypical small town where everyone knew each other, and nothing ever happened. In my imagination, the sleepy town had an equally sleepy hospital and GP clinics - a close-knit community that made it difficult for outsiders to fit in.

I was prepared to be lonely and bored in yet another bastion of poor immunisation amongst the beauty of the North Coast. However, despite what the locals will jokingly tell you, I found Grafton to be bustling with activity. There was always some festival or local event, from the pomp and ceremony used to celebrate the jacaranda trees with tourists from around the world, to the Grafton show or even the competitive weekly pub trivia. Locals warmly included you into the local community. Strangers greet you in the street and generous unexpected hospitality was often offered, even if you had just met them.

The town itself was beautiful, a mix of tropical plants and brightly flowered trees matching its warm weather and stunning architecture, such as the ancient clocktower watching over the town centre. Even the local prison draws the eye with its gorgeous brickwork.

The sleepy emergency department I had imagined was soon refuted. The department always seemed busy, brimming not only with highly skilled staff eager to teach but also rare and unusual medical conditions you never thought to see outside of a textbook.

UOW Students Holly, Lara, GP Preceptor Nic Cooper and Practice Manager Carol Pachos – GP Super Clinic Grafton

Similarly, I initially found my placement with a local GP super clinic overwhelming. Patients were complex and specialist services, especially mental health care, were often in short supply. So too were GPs, with many patients frustrated at having lost their preferred doctor yet again. I could soon commiserate. When seeking my own GP, I realised most had closed their books.

As GPs came and went, over time I learnt the value of continuity of care and the importance of a thorough approach to each patient. Screening, for example, was often forgotten unless made habit. Guiding me was my GP preceptor who, through parallel consulting, allowed me the freedom to safely manage patients while learning from more experienced clinicians. Seeing patients before he did, made me take initiative and responsibility for my patient care and realise treatment is often a compromise. It facilitated working in a team with practice nurses, allied health and other doctors with a free exchange of thoughts, knowledge and ideas.

When asked to comment, my GP preceptor noted that not only did medical students help keep his knowledge refreshed, and sometimes updated, but also allows transfer of tricks-of-the-trade that could not be learnt from textbooks. Medical skills could be applied holistically, while giving students an idea of what was happening in the 'real' world outside hospital medicine.

Overall, I have found my Grafton placement a very positive experience that not only met, but well and truly exceeded, my expectations. It has changed my clinical approach for the better and I couldn't recommend it highly enough.

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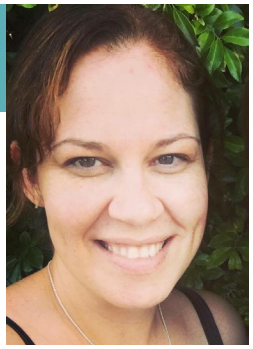
Women in Medicine



Marissa Barker

by Dr Marissa Barker

Rural medicine continues to grow from strength to strength, with Lismore a leading centre for excellence. In 2018, we have welcomed 12 new rural preferential recruits (RPRs) to Lismore Base Hospital where they will be completing internship and residency over the next two years.

LBH is an attractive location for new graduates, offering terms across a broad range of clinical specialties along with a reputation for exceptional senior clinician support. Additionally, it is becoming increasingly evident that lifestyle influences, the allure of rural clinical practice and the culture and backdrop of the Northern Rivers hold both personal and professional appeal.

On 31 January 2018, a welcome dinner for the newly commencing interns was held at the Lismore Workers Club, hosted by the recently formed Women in Medicine and Men in Medicine groups, with support from LBH and the North Coast Primary Health Network.. The dinner was a great success, with 40 attendees coming together to welcome our newest clinical colleagues. It was wonderful to see doctors of all seniority at the event, many of whom have been practicing in the Northern Rivers for several decades. This was a rare opportunity for new interns who were starting their first week.

Dr Jane Barker spoke to the Womens' group about the importance of taking time to look after ourselves, which is a sentiment we can easily forget in our competitive race to consultancy. She reminded us that we are privileged to practice medicine, and that we should always remember that the most integral part of good patient care is compassion, warmth and kindness.

We hope to continue to expand the Women in Medicine and Men in Medicine groups, with a focus on doctors' health and wellbeing. We recognize that in order to provide high-quality care to out-patients, doctors need to be well themselves. We hope to foster connections, friendships and mentorship with our clinical colleagues by meeting in informal settings. Please keep an eye out for our next event in the coming months.

A special thank you to Dr Susan Velovski, Specialist General Surgeon, and Dr Katherine Willis-Sullivan, Director of Medical Services, who helped to make the 'Intern Welcome to Lismore' event possible. Also many thanks to Lismore Base Hospital and the North Coast Primary Health Network for their sponsorship of this event

If you would like to join the mailing list for notifications of events hosted by the Women in Medicine group please contact Marissa Barker on **Marissa_238@hotmail.com**

Medicine men pursue work-life balance

David Glendenning

by Dr David Glendenning

At the start of this year Dr Katherine Willis-Sullivan (DMS of the Lismore Base Hospital), and Dr Sue Veloski (local General Surgeon) advised me that a 'Women in Medicine Night' was being organized, and suggested it might be good to have a similar event for men.

Our task as clinicians, male and female, is demanding, both intellectually and emotionally, and at times physically. We must pass through numerous training barriers and overcome examination hurdles, all while seeking to provide excellent care to our patients.

Hopefully somewhere along the way we also look after ourselves. While the concept of 'Clinician Wellbeing' may not be new, recent reviews into the culture of medicine have brought this into stark relief. A further example was provided recently with the RACP Primary examinations, and the immense distress and disruption this debacle caused to candidates sitting exams.

On 31 January having teamed up with my fellow colleague Dr Marissa Barker, we held the first combined Women and Men in Medicine event. This event also served as a welcome for the new 12 rural preferential recruits (RPRs) to Lismore Base Hospital who will be completing their internship and residency in Lismore over the next two years.

An expert panel was assembled, comprising several newly minted consultants including Dr Joe Churton (Respiratory), Dr Rick Lane (Emergency), and Dr Joe Gormally (Oncology), and senior registrars Dr Cam Hollows (GP) and Dr Shane Clark (Orthopaedics). A series of questions was put to the panel: How do you deal with a bad day at work? What makes you want to turn up for work each day? Why Lismore? How do you survive our training? How do you stay sane?

Several themes emerged. Firstly, that Lismore and surrounds is a great place to work; due to the collaboration and support between colleagues and ongoing interest from the wide and varied pathology encountered.

Secondly, having pursuits outside of medicine is key to staying sane. Whether this be through family, sports or artistic pursuits, or other activities/interests, this is an essential part of clinician wellbeing.

Thirdly, having colleagues to debrief with, whether they are local or accessible via phone, is essential to ensuring clinician sanity after encountering tricky patients or unexpected outcomes. .

The second half of the evening was a combined meal with our Women in Medicine colleagues. Throughout dinner several of the 'old guard' shared a brief synopsis of their careers: Dr Paul Laird (Respiratory), Dr Andrew Binns (GP), Dr John Graham (Vascular Surgeon) and Dr Jane Barker (Paediatrics & GP). This provided a great bookend for the night, hearing career excerpts from senior doctors, each with 30+ years experience in wide and varied roles working around the globe, and each deciding that Lismore was where they wanted to settle.

This event provided a great networking opportunity, excellent career advice and readily applicable tips for clinician wellbeing. I look forward to seeing you at the next event.

All at sea with scalpel in hand

by Dr Richard Arnot

During an interesting six-month internship at the West Cornwall hospital in Penzance, Cornwall I looked for a berth on a square-rigged sailing ship with the intention of sailing round the world. Fortunately common sense prevailed, and instead I joined P&O as junior surgeon on the SS Canberra, and set off from Southampton in August 1966.

It was a great introduction to life at sea - romantic, wicked, and a wonderful experience in life affairs. I rubbed shoulders with the great and famous, including Cary Grant and his wife Dyan Cannon, with whom I was on first name terms.

During that voyage I had one day ashore in Sydney, one of the very few during the trip around the world, and fell in love with Australia, lying on starlit Bondi beach.

My travels with P&O ended in tears after six months when, following my refusal to obey what I regarded as an unreasonable order from my senior officer, I was charged with mutiny; fortunately I'd the foresight to arrange a transfer to the Union Castle Shipping Company.

Early one morning after we docked at Southampton, I borrowed a trolley from the stewards, rolled my bags down the gangway, and up onto RMV Cape Town Castle, which just happened to be moored behind us.

The six months on that ship were some of the happiest and most adventurous of my life. My good fortune was greatly enhanced by having the vessel commanded by Captain Doug Southam. Doug was the epitome of the sea-going hero - cap worn at a rakish angle, piercing blue eyes that missed nothing. He had received a medal during WW2 for sinking a German U boat. Captaining an armed British merchantman in mid-Atlantic, his ship chanced upon the enemy conducting repairs on the surface. The gunner got off a lucky shot, striking the sub's conning tower, and Doug promptly ordered 'full steam ahead', ramming the submarine amidships, and sinking it.

The Cape Town Castle did a six week round voyage between Southampton and Cape Town, and back, calling into St Helena and the Ascension Islands, and Swakopmund in German West Africa. I had a few days ashore at each end of the voyage.

It was during a stop-over in Cape Town when I met an orthopaedic surgeon who had fixed my broken leg while I was a schoolboy in Rhodesia, now a lecturer in Anatomy, and he offered me a demonstrator-ship when I left the navy to begin serious training for surgery.

One day, after leaving the island of Madeira, I was visited by a cabin boy with obvious early appendicitis. Despite IV tetracycline, the only antibiotic we had aboard, he developed peritonitis, and clearly required urgent surgery. The only other doctor on that voyage was an ophthalmologist who had not strayed into an operating theatre in years, so it was all up to me.

By good fortune, in 1965, while I was on call as the surgical intern at the Dundee Royal Infirmary, a 12-year-old boy had been admitted with acute appendicitis. My registrar, who had over-indulged at the bar in the hospital mess earlier that day, informed me that this would be my first operation, with a nurse assisting and he supervising. I am pleased to report my first laparotomy and appendectomy was a success.

We had a makeshift operating theatre on board, complete with a collapsible operating table, a Boyles open-ether anaesthetic machine, an experienced ex-theatre ships nurse, and a hospital orderly.

As both surgeon and anaesthetist I attempted to induce the lad, only to discover I was unable to pass an endo-tracheal tube. Reverting to a pharyngeal tube airway the orderly bagged the patient with a supply of oxygen and ether.

No sooner had I started the incision than the airway (which had a round cross-section, not the usual flattened one) rotated so as to become partially occluded, the poor orderly on the bag could do nothing to help, and the operation was performed with this stout young lad gasping for breath throughout.

I can still vividly recall the nightmare operation 52 years later, including being able to successfully locate and remove a gangrenous appendix

Dr Richard Arnot

Towards the end of my time aboard, once again in mid-Atlantic, the captain's 'tiger' (as his steward was known) tapped on my door early one morning, and woke me with "Doctor, the captain sends his compliments, and asks if you could join him on the bridge".

Dougie fixed me with a piercing blue eye and shoving a radio report into my hands said 'Good morning doctor, I am sorry to wake you, do you think we can help?' The report stated that a merchant ship in mid Atlantic had a sick officer on board with suspected appendicitis.

The captain changed course to a rendezvous point in mid ocean, and about fours hours later a rusty little tramp steamer came into sight, and we hove-to about 400 meters distant. A life-boat was lowered from the other vessel and Budge (my new but slightly corpulent orderly) and I were transported across, while the crew cooled the engine with buckets of sea-water sluiced over it and bailed from the bilges.

There was quite a swell running but we managed the rope ladder without incident, and a brief examination confirmed the diagnosis. The young man was strapped into a Stryker cane stretcher, and carefully lowered into the lifeboat. Budge followed, but unfortunately missed the last rung on the ladder, and landed heavily on top of the patient who fainted from shock.

The ships rails were lined by excited passengers when we returned, and transferred the patient to our sick bay. This time I was smart enough not to attempt another general anaesthetic, but I had read somewhere about surgeons operating with only sedation and local anaesthetic, and this worked out just fine.

The lad snored gently away during the

operation with Budge supervising the airway, and as the peritoneum was opened, the appendix, which had been lying directly beneath, popped up out of the incision and it was the work of a moment to ligate the artery and the base of the appendix and remove it.

The captain offered to do whatever he could to make the operation less dangerous, and he assisted by slowing the vessel down, and changing course so that the ship was running with the swells that made the motion on board a lot easier to handle.

This time recovery was almost instantaneous. I ordered the young officer to stay in the hospital for two days, but next morning he begged and implored me to let him out early, explaining that he had been at sea in a male-only ship for many weeks, and the charms of all the lovely young ladies on board was simply irresistible.

Months later I received a card of thanks and the report that he had been able to return to "full duties" within 48 hours.

I remained on the ship for her final voyage before she was sold to a Dutch shipyard to be broken into scrap metal, thus completing the final circle – my parents had met on her maiden voyage to South Africa in 1937.

Before we finally docked at Southampton almost exactly a year to the day from when I had set sail on the Canberra, I had to ditch the contents of our pharmacy over the side. I did however retain one small bottle of Dovers Pills containing a mixture of opium and ipecacuanha, which I had discovered was a wonderful cure for flu in combination with a liberal dose of ship's brandy.

That would not be the end of my seafaring life, for I later embarked on a series of Arctic and Antarctic voyages, more experienced and better equipped for any medical emergencies that might occur.

* **Richard Arnot** is a Northern Rivers-based surgeon. He was born in England and educated in southern Africa, and graduated from medical school at St Andrews University in Scotland. After a year in the merchant navy he began surgical training in Cape Town and later in Britain. He holds a Masters degree in surgery and is a fellow of the Royal College of Surgeons in Edinburgh and the Royal Australasian College of Surgeons. He has been recently appointed to the Southern Cross University health clinic where he runs a bulk-billing general surgical clinic one day a week.

BAC awareness discourages risky driving

A survey* of young people attending a regional music festival has found that factors such as an awareness of their **blood alcohol concentration** (BAC), and having more than five hours sleep and less than six drinks the night before made them feel safer to drive in the morning.

The survey of 409 participants - 66 were drinking during the morning of the survey and were excluded - 60.4% of them male, was conducted by medicine students from Western Sydney University, overseen by Dr Sabrina Pit from the University Centre for Rural Health North Coast, and **the STEER youth project**, which provides voluntary breath testing at North Coast music events and other events, including private functions.

To be published in the international online journal **Substance Abuse Treatment, Prevention, and Policy** the survey found that although only one-in-five interviewees felt completely safe to drive that day, half of them intended to do so. Of those, two in five changed their intention of driving after reading their actual BAC level from the breathalyser.

For each extra passenger present within a car, an individual was 50% more likely to drive at a later time after having received their BAC reading.

The main findings were that people with a full licence, more than five hours of sleep and less than six alcoholic drinks, and estimated BAC levels of less than 0.05 felt safer to drive.

"These findings present important implications for alcohol and road safety public health messages and interventions directed towards young people".

Participants who slept more than seven hours the previous night were three times more likely to feel safe to drive than those who had less than five hours of sleep

Another significant observation was the high level of alcohol consumption amongst festival goers - the median number of drinks in the last 24 hours for participants was 12 standard drinks, twice the number of standard drinks considered to be a binge.

The authors said the results indicated "more awareness may need to be placed on safe driving practices, or alternative transport options by music festival organisers for those participants who do not feel safe to drive."

They added, "Encouraging young individuals to self-evaluate their BAC prior to driving has the potential to increase self-awareness regarding safety to drive.

Further interventions targeting youth regarding how BACs are measured, the lasting effects of alcohol within the body hours after drinking cessation has occurred, and education on the effects of compounding factors resulting in decreased safety on the road such as sleep may support this endeavour."

* Perceived driving safety and estimated blood alcohol concentration the morning after drinking amongst young Australians attending a music festival: A cross-sectional survey.

Mario Fernando; Johanna Buckland; Prashina Melwani; Vanessa Tent; Phil Preston; Sabrina Winona Pit

Pairing wine with food – a balance of power

by Dr Chris Ingall

Wine is made to be drunk with food, its taste and structure perfectly complementing and enhancing the eating experience and ingestion, as well as the process of digestion.

The pairing also dictates a measure of moderation, as the drinking stops (or should) when the last bite is taken. A marriage made in heaven, and something you can optimise at home, matching the type of food to the age and variety of wine (particularly if you have invested in a cellar).

Other alcoholic drinks don't come close, as the flavour profiles of beer and cider are much more limited, and fortified wines and spirits are overpowering in their pace of inebriation, which to me takes away from, rather than adds to, the experience of sharing a meal.

If you are eating out, the modern day reality is a little more complicated. It goes something like this... you walk into a restaurant and immediately smell the food. Maybe you have even picked the place because of a particular dish they serve. Unless it's a wine bar, or allows BYO, the next thing you notice is the stratospheric price of the wines. They are usually young wines, even the reds, and if you are used to drinking riesling, semillon and just about any red in their prime, you'll be like me and order a beer with the meal. (If you like a chardy, pinot gris, sav blanc or pinot noir you will be ok, as they are often more approachable when they are young).

But let's imagine for a moment this restaurant has some affordable aged wines. you really do have the full palate of flavour matches available. As with any good marriage it works better among equals. So the first thing to sort out is the weight of the wine. By this I mean the intensity of flavours, particularly tannins, as a big tannic wine (think McLaren Vale reds) will need a flavoursome steak or a stew to arm-wrestle it into submission.

Conversely, a fragrant, ethereal WA riesling will be easily overpowered, and thus demands a delicate match such as crab or whiting. Alcohol often parallels the other components, and that McLaren Vale Shiraz will often be at 15%, the riesling 12% alcohol or less.

Once you have a balance of power, you'll taste both the food and the wine, which gives you immediate bang for your buck.

Next for me is the fat and acid equation. For example, I prefer a high acid wine like riesling or semillon with a fatty pork dish, as the acid cuts the fat beautifully, like a sorbet between every bite! That's why fish and chips goes with champagne! If you prefer a red, pick a medium bodied red with good acid, maybe from the high country (Seppelts) or the Hunter (Tyrrells). Pinot noir is a standout with meals of mid-weight, such as stir fries, although it goes with duck particularly well. It's really a white wine in disguise.

And then on to the flavours within the food, such as lime (riesling), lemon (semillon), buttery sweetness (chardonnay), and the flavoursome proteins of lamb (shiraz) and beef (cabernet). You should think of foods that have those flavours embedded in them, like Asian dishes, and pick your wine accordingly.

The age of the wine is critical here, as a wine should ideally be in its drinking window for you to get the best from it. Think 3 to 7 years for most Aussie whites, and 5 to 10 for the reds, if they sell at a median price point. You wouldn't eat undercooked food, would you?

If you are lucky enough to get your hands on a higher shelf 10+ year-old Barossa GSM, Coonawarra cabernet or Eden Valley shiraz to go with your main, your pleasure multiplies, as the tannins start to soften while the fruit flavours develop, significantly broadening the possibilities of food matching.

It's like waiting for roses to open. As for desserts and cheeses, wines with high sweetness levels (think ice wine or botrytis affected grapes) can put both in a good light, but the wine must be sweeter than the food!

Finally, there is no better way to understand the relationship between wine and food than to ponder the old wine trade adage of "Buy on apple, sell on cheese". Apple contains tartaric acid, and this exposes any wine faults which may be present, while the fats in the cheese coat the tongue and hide these same faults. You'll never find an 'apple platter' at the cellar door, that's for sure. And something I don't need to tell you is that the company you are enjoying is the best sauce for the match, enriching the experience immeasurably. A joy shared is a joy doubled, after all.

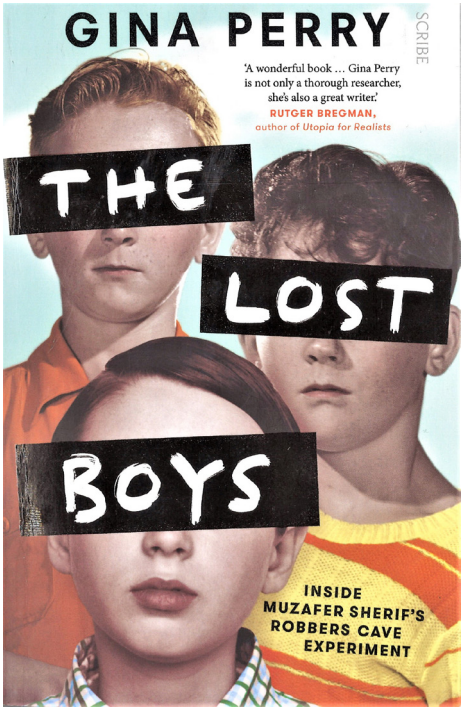
Dr Chris Ingall is a Lismore-based paediatrician who writes on wine, food and lifestyle issues.

Book Review

Reviewed by Robin Osborne

The Lost Boys

By Gina Perry
(Scribe 400 pp, $32.99)



Not to be confused with Lachlan Philpott's current play *Lost Boys*, about gay hate murders in 1980s Sydney, this remarkable book recounts the behavioural experiments involving young American boys in the 1950s by Turkish-born Muzafer Sherif, later to become "a giant of social psychology".

Australian author Gina Perry, herself a psychologist, travelled far and dug deep in pursuit of a tale that is truly stranger than fiction. Drawing on records and extensive interviews she delves into Sherif's 'Robber Cave Experiment', starting with two earlier projects, the first moderately successful, the second a total disaster, that preceded the 1954 undertaking that would make his name.

The rationale for all three was that two groups of boys taken on what they believed to be a normal summer camp would, through varying degrees of intervention by Sherif's team, who posed as camp staff, prove his theory about the mutable bonds of loyalty and the power of groups.

"The first stage was mingling and making friends… just a day or two. In the second stage, 'intragroup relations', the boys would be separated into two groups and each group given a chance to develop its own identity.

"In stage three, 'intergroup relations', the groups would take part in a series of competitions that would cause hostility and conflict… Stage four was the 'integration phase', where the two groups would come together in the face of a larger, shared problem."

She adds, "It wasn't the boys' personalities that made them behave like savages - after all, he had chosen normal, well-adjusted kids… Prejudice and conflict arises between groups of people, he argues, because of competition for limited resources.

"When groups of people compete for a valuable prize and there's only one winner [bizarrely, the prizes were mostly bowie-style knives] hatred and violence is inevitable. But it is reversible, according to Sherif."

The 1949 camping trip ended without peace between the two groups, with the larger 1953 version going even worse, with brawling, verbal abuse and food fights.

Not surprisingly, the author draws a parallel with teacher William Golding's attempt in 1951 to understand 'the nature of small boys' by taking two groups to Salisbury Plain, near Stonehenge, and instructing them to attack each other: "He hinted that there was serious violence, even the risk of boys being killed…"

Hence his famous novel *Lord of the Flies*.

In 1954 things started similarly when Sherif, helped by a research grant from the Rockefeller Foundation - which would become deeply concerned about his methodology - again used the setting of a summer camp to study group dynamics.

The location was Robbers Cave National Park in Oklahoma, a place with a colourful past. The 22 chosen 'subjects' did not meet each other beforehand, and their parents were told only that the camp was a chance to study which boys would become leaders and which would be followers.

Sherif had four main staff, mostly academics (and by coincidence, Native Americans) who would surreptitiously help fuel hostility and record observations.

With little adult help the boys built latrines, erected tents, chopped wood and cooked, then moved on to arranged team sports and contests of strength, such as tug of war. They gave themselves team names - the Rattlers (the woods were alive with snakes) and the Eagles.

The contests were winner-take-all affairs, again the usual prizes were valuable knives, and as Sherif had hoped, all hell broke loose.

In his words the boys changed from being 'cream of the crop' to 'disturbed, vicious… youngsters', smearing their faces with commando-style soot, raiding the other team's campsite, capturing their flag, stealing their prizes, ruining their gear.

This time, however, a cooperative project was arranged, then a bus excursion to a nearby state. The boys reconciled, the experiment concluded, and Sherif went on to pen an acclaimed book, *The Robbers Cave Experiment*, and enjoy a glittering academic career.

The author visited the camp locations and interviewed many of the now elderly participants and staff members (Sherif died in 1988). She concludes that, "It seemed to me that what happened at Robbers Cave wasn't a test of a theory so much as a choreographed enactment, with the boys as the unwitting actors in someone else's script… In an experiment about group influence and inequities in power, the men seemed blind to their own role as a powerful group in the camp.'

And what of the key role of Sherif himself?

In the last section of the book Perry finds the Turkish village where he grew up, then visits Izmir, the former Smyrna, where he boarded at a leading college. As a 15-year old he joined the Young Turk nationalists, and

continued on P32

Book Review

continued from P31

in 1922, his last year of school, witnessed the Turkish sacking and burning of the multi-ethnic port city.

Did his experience influence the group experiments he would later conduct?

While never speaking personally of the conflict he raised it once in a textbook: "It influenced me deeply to see each group with a selfless degree of comradeship within its bounds and a correspondingly intense degree of animosity, destructiveness and vindictiveness toward the detested outgroup..."

As Perry writes, "There's no hint of exactly which groups of compassionate-one-minute, brutal-the-next people he was referring to... he has reduced the turmoil and trauma of war to an abstract and intellectual problem - one he would 'devote his life' [his words] to studying."

Travelling between the USA, Turkey, where he was eventually banned, Berlin, where he quickly learnt German to take up a faculty position, Sherif was brilliant, abrasive, a fervent then lapsed communist, a recipient of CIA funding for a covert study on adolescent gangs, and finally, diagnosed with bipolar disorder.

His talented wife Carolyn, who predeceased him, had unreservedly shared his belief in social psychology. At night, often fuelled by local bootleg whisky, he had phoned her from the Robbers Cave site to report on the experiment's progress.

They made quite a team.

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Advertorial

Why I am passionate about bariatric surgery: Dr Harald Puhalla

The world-wide health impact of obesity led the World Health Organisation to publish strategies in 2004 to try to counteract the pandemic. It is well documented that weight-loss surgery is the most efficient treatment for obesity and has evolved over the last few decades. Interestingly, bariatric surgery is still often seen as cosmetic surgery, as a quick-fix or "the easy way out" for a weight problem. This is despite a large Swedish study showing that surgery is much more successful for long-term weight-loss compared to dieting and can lead to many health benefits. The study showed that fifteen years after undergoing bariatric surgery, 30 percent of patients no longer had diabetes but only seven percent of patients who received usual care were in diabetes remission.

Dr Harald Puhalla is one of the Gold Coast's specialist obesity surgeons who is passionate about weight-loss and weight management. He began his career as a cancer surgeon and completed a PhD in liver cancer before pursuing his passion for obesity surgery due to its positive long-term health implications.

With two thirds of Australian adults considered overweight or obese, bariatric surgery is one of the most rapidly growing divisions of surgery. It is considered a safe operation, with a significantly improved risk profile over the last 25 years.

To be considered for bariatric surgery, Dr Puhalla said patients need a thorough work up and in-depth discussion about the implications. Often the operation (e.g. Sleeve gastrectomy) is not reversible and patients need a good understanding of the necessary lifestyle changes.

"It is important to take regular vitamin supplements and regular blood tests down the line are suggested to detect any potential deficiencies of vitamins and minerals early," Dr Puhalla said.

"Time has shown that only getting a weight-loss operation does not guarantee long-term weight-loss success with the expected associated health benefits. Research has shown that ongoing follow-up by specialist health professionals helps to counteract any reoccurring wrong eating habits and weight gain, which leads to reoccurring metabolic problems and increased cancer risks."

There is a link between cancer and obesity – with around 3900 cancer cases in Australia each year attributable to people being obese or overweight.

"So many resources and so much pain goes into cancer treatment but despite all this effort the cancer can often come back," Dr Puhalla said.

"If people have substantial weight-loss, they can significantly decrease the risk of developing 13 different types of cancer and several other health issues including cardiovascular disease, Type 2 diabetes, some musculoskeletal conditions and more."

Bariatric surgery has many other positive spin-offs, with research showing that it can increase life-expectancy, self-esteem and can help with fertility.

"I want to prevent these health problems as much as I can, and this is why I am so passionate about bariatric surgery," Dr Puhalla said.

"Bariatric surgery is the only option for most obese people with many patients describing their surgery as 'life-changing'.

"One lady was 36 and had a BMI of 37 before the operation. She now has a BMI of 24. She is so happy and told me that she is now the person she always wanted to be. How can I not be passionate about this? I truly enjoy observing my patients going through their weight-loss journey."

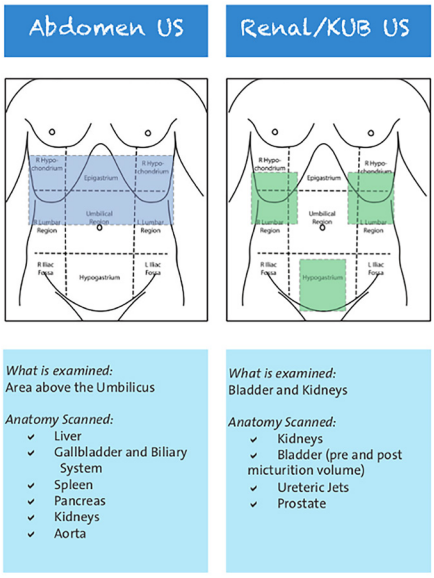
Improving Radiology Requests

North Coast Radiology group has recently released some resources to improve and streamline general practitioner ordering of radiological investigations.

The online forms for magnetic resonance imaging and bone densitometry specify the MBS item number for approved procedures. This is more efficient and makes it clear at the time of the request whether the investigation will be Medicare rebatable or not.

The MRI request form asks for a recent eGFR if the patient has renal impairment and also reminds the user of the absolute contraindications (cardiac pacemakers) and relative contraindications (Intracranial aneurysm clips, intraocular foreign bodies, metallic implants (including cochlear) & extreme claustrophobia) for the procedure.

The general radiology request lists patients instructions for the more specialised requests and all forms are available in hard copy for direct printing from the practitioner's electronic health record. NCR can provide support to practices to enable this if required.



A fact sheet outlining when and how frequently obstetric ultrasounds may be ordered under Medicare eligibility criteria is available. The sheet also specifies the extensive list of conditions that qualify for a Medicare rebate for nuchal translucency testing between 11.5 and 13.5 weeks gestation. It notes that the associated bloods tests are preferably done 3 days before the ultrasound.

GPs frequently order abdominal ultrasound but often should be more specific in their request. NCR has produced a quick guide to the five different types of subdiaphragmatic ultrasound (upper abdominal, renal/KUB, appendix, pelvic and groin). Transvaginal ultrasound is an option in pelvic ultrasound if not contraindicated and the patient consents.

Other resources are also available online from their referrer support page and practitioners can request access to view their recent investigation results and images through the physician portal.

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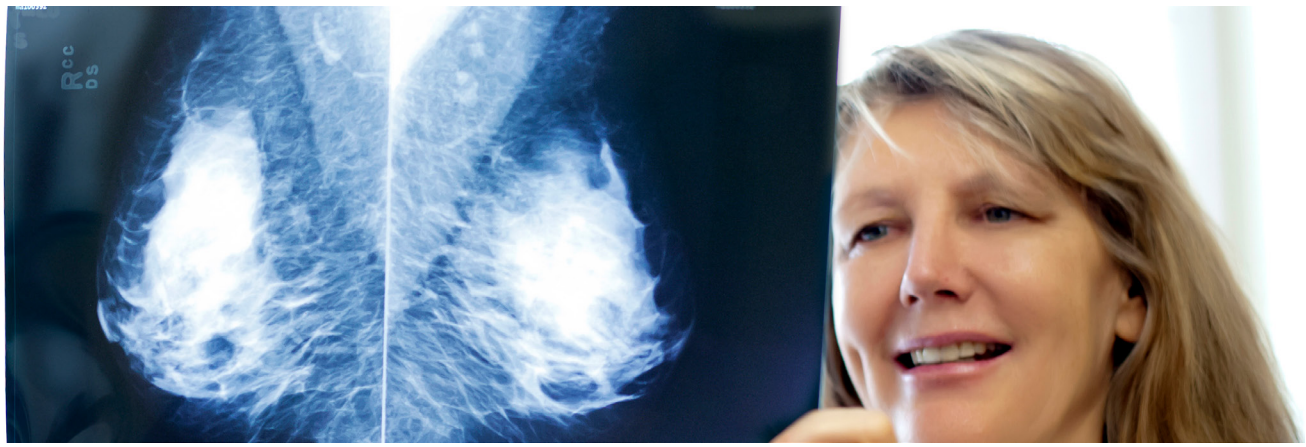

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Where the blues beats the booze

by Rachel Guest

April marked the 29th anniversary of Byron Bay Bluesfest, Australia's Contemporary Blues and Roots Festival. From a modest crowd of 6000 people in 1990, the five-day festival now attracts 100,000 revelers each year and some of the world's biggest music acts. Bluesfest has clearly grown in size over the last three decades, as has the Australian music festival scene with more and more festivals springing up each year and attracting ever larger audiences. But while Bluesfest has ballooned, it has managed to retain its fun family feel with much less drunken debauchery and less drug related incidences than other festivals of a similar scale.

As a millennial, I've been to my fair share of music festivals over the past 15 years. However, this year was my first Bluesfest and it was a markedly different and welcome experience. It's no secret alcohol has come to make up a large part of youth festival culture, the day becoming as much about socialising with friends as the music itself. Bluesfest on the other hand, attracts a different kind of festival-goer, one that rightly prioritises the blues over the booze.

It's true the average age of a Bluesfest attendee skews older than most of the country's other music festivals, but it appeared even younger Bluesfest patrons were happy to cut back on their alcohol consumption in honour of the music. Gerard Duffy of Brisbane commented, "It'd devastate me not to remember in vivid detail seeing Robert Plant play the music I grew up on, and with one too many beers that's quite possible."

Perhaps this shift in priorities can be attributed to the arts and culture focus of Bluesfest, or perhaps it's reflective of a broader festival trend. Bonnaroo is a major music festival in the US, headlined this year by Eminem, The Killers and Muse. It is also home to Soberoo. According to the Soberoo community **Facebook page**, "Soberoo is a group of clean and sober music fans who choose to remain drug and alcohol-free

Image of Bluesfest Byron Bay, 2018 crowd by *Markus Ravik*

at Bonnaroo and other music festivals." Available to all patrons, these meetings are free to attend and are 100% anonymous. Average attendance per session is around 50-75 people.

Global festival **Daybreaker** takes alcohol-free festivals a step further, hosting entirely sober events. Originating in New York, Daybreaker has been featured in **The New York Times** and **The Huff Post** and has expanded to 22 cities including Sydney and Melbourne. **Co-founder Radha Agrawal told NBC News** she created Daybreaker to see if people were "as tired of alcohol-induced nightlife as she was." She wanted to recreate the nightlife and festival experience by eliminating alcohol from the equation altogether and providing healthier options such as green juice and tea.

Closer to home, New Zealand based **No Beers? Who Cares!** is an organisation all about shifting attitudes around how and why we drink. No Beers? Who Cares! throws monthly parties and mixers and requires a 100% sobriety commitment from its patrons. Founder Claire Robbie as told to **the Daily Mail** states, "it's not about giving something up, but seeing how much you gain."

Which brings me back to Bluesfest; yes, the same punitive measures such as long lines, quota systems, high drink prices, and designated drinking areas were in full effect at Bluesfest, as they are at nearly all international music festivals. But the more significant deterrent to excessive drinking seemed to be the bands themselves. Unlike the usual headliners that tour the summer festival circuit, Bluesfest attracts true music icons, and it seemed to imbue the air with a particular kind of reverence. For many attendees like Gerard Duffy, missing out on a potentially once-in-a-lifetime performance in favour of a few drinks with friends in the beer garden just didn't seem right.

As the festival scene continues to grow and drug and alcohol consumption continues to be an issue for medics, organizers and attendees alike, perhaps it's time to introduce a new narrative into festival alcohol restrictions, one that highlights more of what we gain, and less of what we give up.

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We are very pleased to welcome Dr Juan Ortiz to our Lismore team

Dr Ortiz joined Sullivan Nicolaides Pathology in 2017. Based at the Lismore laboratory he is passionate about patient care, research and teaching. He publishes in his fields of interest and in 2018 contributed to the chapter on ophthalmic pathology in the third edition of the text book Clinical Cytopathology, Fundamental Principles and Practice. He has lectured at The University of Queensland Medical School and taught medical students, pathology and ophthalmology residents rotating at HMH in Houston. He has presented at conferences nationally and internationally and is a member of the Royal College of Pathologists of Australasia (RCPA), the United States and Canadian Academy of Pathology (USCAP) and the American Association of Ophthalmic Oncologists and Pathologists (AAOOP).

As a pathologist at the only private pathology laboratory in Lismore, Dr Ortiz plays a key role in local healthcare. He is strongly committed to the delivery of high quality regional pathology services as well as taking an active role in the local community.

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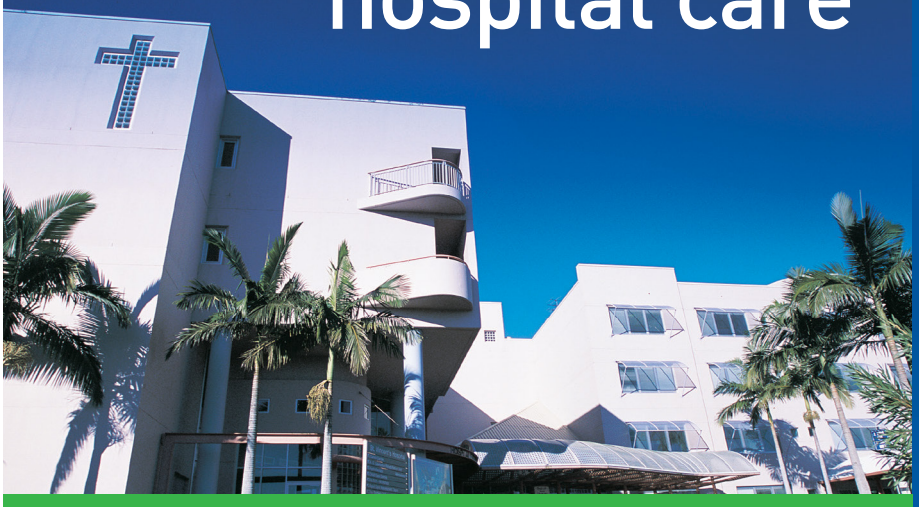

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