Eric Fisher
on a life in medicine
A lifetime of wisdom

Waiting in Dr Eric Fisher’s Northbridge practice to see him between patients, there’s time to contemplate the great man’s life in medicine. A life that has, to date, been one of extraordinary giving and commitment to general practice.

At 87 years of age Fisher still sees patients, who, he later tells me, ‘all take responsibility for themselves because nobody can cure a patient except themselves’. He describes quite matter-of-factly, in his short autobiographical notes, that he ‘continued with listening to patients to help them find out why they became ill’. He acknowledges that statement: ‘The training now is almost totally on diagnosis and treatment, but if you know why they get ill they can manage themselves.’ The patients can ‘often do something about that, which is the precursor to illness’, he adds, and he stresses the importance of ‘getting people to try and understand themselves’ because so many of their illnesses are consequences of their lifestyle choices and behaviour.

Fisher has been practising medicine since 1948, but he’s been thinking about it since 1930 when, as a 5-year-old, his father – a country GP – removed his tonsils and adenoids with a chloroform anaesthetic. By the time he was 8 years old he had accompanied his father on numerous visits and ‘seen people who had died by accident, violence or natural causes’.

Past president of the RACGP, Rose–Hunt Medal recipient, Member of the Order of Australia and GP legend Dr Eric Fisher talks about his life and medicine.
LEAD STORY

Fisher has vivid memories of one trip with his father that sadly ended with a body needing transportation back to the town. ‘My dad said to the policeman “Put the body in the back of the car,” and I yelled my head off,’ he said. ‘I didn’t want a body in the back of our car!’ The memory of Geoff Bucknell remains poignant too. Bucknell was a farmer who Fisher and his father found dead under a plough after a team of horses bolted in the middle of a fallow paddock. His father performed his physician duties by the flickering light of a hurricane lamp in the black of night.

Fisher grew up in the small town of West Wyalong about 470 kilometres west of Sydney. His father, the local GP; and his mother, a nurse, met when she was on a trip to the small town. The pair married and had three children who grew up playing in the bush with a landscape only Australia could provide – gold mines, mullock heaps, gold fossickers, dolly pots and a eucalyptus oil factory.

Although Fisher knew from an early age he would practise medicine, a medical career wasn’t so straightforward for his father, who left school at the age of 12 years. ‘He worked in the government printing office as a printer’s devil; he carried ink,’ Fisher said, describing his father’s first job. ‘At the age of 13 or 14, he decided he’d like to join the public service.’ Then after several years working for the government and completing an arts degree in 1912, his father had saved enough money to fund his medical studies. He graduated from The University of Sydney as a general practitioner in 1919. He was 38 years old. Soon after he went into a junior partnership in the same West Wyalong practice that his son and daughter-in-law were to inherit more than three decades later.

‘He took a lot of pride in what I was doing, and in the fact that I was following him and going to be a general practitioner,’ Fisher said of his father. ‘His ambition was that I should follow him in his practice. He’d been there for 36 years, and that’s all he’d known – country general practice in the one town.’

However, before Fisher was ready to take the reins of general practice from his father, he was to travel overseas and gain valuable surgical expertise. In 1951, he embarked on SS Tasmania Star as a ship’s doctor, and when he set foot on English soil it was the beginning of an adventure that enriched both his life and his career.

In London, Fisher enrolled in the primary fellowship course at the Royal College of Surgeons. Unfortunately, he had a penchant for enjoying himself, rather than studying, and he failed his final examinations.

Fisher worked in Munich assessing migrants for Australia, and went on to explore the devastation of Central Europe after World War Two. Of Berlin, he said, ‘The Tee Garten was levelled and levelled for acres and acres; there wasn’t a building standing.’ And of the aftermath of the Holocaust: ‘I saw Jewish graves from the train.’

When he returned to England, Fisher worked in various hospitals performing surgery and broadening his skills, which were to stand him in good stead when he returned to general practice in Australia. But at that time he was keenly focused on the Royal West Sussex Hospital in Chichester, where his life was changing forever. It was 1954, and a Welsh house surgeon named Anne came to work in the hospital. By 1955, they were married and he had a partner who brought warmth and sensitivity and shared his life and profession.

“One of the greatest things I ever did was family therapy training where I began to understand families and how they work.”
'I was brought along up in a family that didn’t show any emotion at all. My wife taught me a lot about emotions and feelings and things like that,’ he said. ‘She has been a great influence on my life.’ For a boy who went to university to study medicine at 16 years of age, Fisher said his maturity was still developing after he left Sydney and travelled overseas. In England when he should have been studying, he was learning about life and when he married, he said, he hadn’t developed his emotional intelligence and extended worldview. Fisher acknowledges his early immaturity, but he doesn’t lay claim to his obvious humility, which no doubt made him a suitable subject to be presented, along with Anne, to Queen Elizabeth on her visit to King Edward VII Sanatorium in Midhurst in 1956, where they were medical officers.

In late 1956, after 5 and a half years, the Fishers left London aboard the SS Tasmania Star bound for Australia. When they arrived in Geelong they went straight to West Wyalong where they would practise medicine for the next 17 and a half years. However, the joy of being back on Australian soil and among family and friends was short-lived because Fisher’s father, who was 75 years old, was gravely ill.

‘When Anne and I came back to Australia in 1956, he welcomed us with open arms and took us into partnership,’ Fisher said. ‘But then he died about 4 months later – he had an inoperable carcinoma and he died on the operating table.’

Fisher was pleased that he’d been able to demonstrate some of his acquired surgical skills to his father before he died. He had pinned a fractured hip while Anne administered the anaesthetic – a procedure that would have impressed any rural GP back in the mid-1950s. The couple also painted the private hospital built by Fisher’s father, renovated the surgery and bought a car. They created a list of local residents they could call on for blood, and if they needed it in a hurry they grouped the patient, cross-matched the blood, bled the donor and transfused the patient. All in a day’s work, Fisher said. ‘We had to be pretty self-sufficient because it was either you or nothing.’

The nearest hospital at Wagga was check 160 kilometres away on a gravel road and, even then, the only specialists in the town were a surgeon and an ear, nose and throat surgeon. It got challenging in West Wyalong; for example, in 1960 they had 70 cases of hepatitis A in the town. ‘We discovered that all the patients lived around pan toilets and so we approached the Bland Shire and got them to extend the sewerage to those areas, and we never had another epidemic,’ Fisher said. >>
’I remember being so tired that somebody rang up and asked me to do a call in the middle of the night, and I must have been so tired that I put the phone down and then I couldn’t remember who had rung me,’ Fisher said. ‘Fortunately, we still had a manual exchange and I said to them “Who just rang me?” and they said it was Harry Wise, and I knew it wasn’t Harry. It was Bill who lived across the road and didn’t have a phone. He’d gone over to Harry’s and asked him to ring.’

The Fishers performed ‘appendectomies, herniorrhaphies, cholecystectomies, partial gastrectomies, prostatectomies and acute surgical procedures such as bronchoscopy and esophagoscopy for foreign bodies’. They also operated on ‘perforated peptic ulcers or intestinal obstruction’, and managed most of the ‘obstetrics including normal, instrumental and caesarean births’. It was a busy time, and in 1963 the only other practice in town closed down. This left them with 9000 patients to care for, as well as their own four children, including one set of twins. True to form they managed, and truer to form they bought the other practice and brought in new partners.

Anne also founded a school medical service and began examining the local children in a caravan with the assistance of a nurse.

‘The biggest influence on me was the College,’ Fisher said of the RACGP. ‘We joined the College in 1967, and in 1968 we went to a seminar in Wagga and that was the beginning, I think, of me beginning to understand families and how they work,’ he said. He is an advocate of whole-person, generalist medical education. ‘Medicine now is divided into four different sections’, he explained, ‘the hospitalist – who practises in hospital; the specialist – who practises as a specialist out of hospital in their rooms; the general practitioner who looks after people when they get sick, and treats them and diagnoses them and hopes they get better; and the generalist, who is what I am – somebody who cares for the whole person’.

A generalist, Fisher added, ‘is somebody who takes all the factors in a patient and looks at why they get ill, what lowers their immunity, what makes them sick, why they have accidents and endeavours to correct the course of the illness’.

Fisher was elected president of the RACGP in 1986, and he is extremely proud of the achievements of the College over the past four decades. In 1960, he said, ‘we established the research foundation, then there was a burst in education and group learning’. The RACGP also convinced the government during his time as president, to establish the fellowship of the RACGP as the end point in the training program. ‘We developed descriptors for consultations,’ he added, and ‘vocational registration was agreed to the day I left my presidency’.

Fisher is an extraordinary man. Devoted to medicine since he was a young boy, under the guardianship of his father, his razor-sharp memory and intellectual curiosity are acutely apparent. When discussing a photograph for the cover, he rejected the idea of posing with his arms folded. ‘Only people who have something to hide fold their arms in front of themselves,’ he said with a sparkle in his eye. And, true to character, he found a much more open and welcoming way to have his photo taken.
A cast of GPs from around Australia has an appointment with the Melbourne International Comedy Festival to perform *GP The Musical* from 17–20 April.

When Dr Gerard Ingham played a song he had composed about general practice to colleague Dr Genevieve Yates, the two shared a ‘light bulb’ moment. Yates – already a successful playwright in her spare time – was intrigued by the character Ingham had created in his song: a smooth-talking doctor with a ‘PhD in applied Medicare’ and a keen nose for profitable practice. Ingham was equally amused by Mr Black, a patient of Yates’ creation who delights in documenting all his bodily functions and sharing the results during his weekly GP appointments. The two doctors decided their characters simply must meet, and so *GP The Musical* was born.

With Ingham’s compositions and Yates’ talent for writing, the pair wove a story around the music and had completed the script within a few months – not a bad effort considering Ingham is based in country Victoria and Yates in northern NSW. They assembled a cast of amateur actors – also GPs – from around the country, and after many hours rehearsing on Skype and a few dry runs, the show premiered at the 2012 GPET conference in Melbourne.

Ingham recalls the nerves he felt during that first show, even though he didn’t have an on-stage role. ‘I was just so nervous, watching to see whether they’d like it,’ he said. ‘I was so relieved when the first laugh came.’

The laughs continued, and by the end of the night the several hundred audience members were standing in unanimous applause. Ingham had hoped doctors would understand the jokes and relate to the scenarios, but what surprised him was how much non-medical people enjoyed the show too.

‘Everyone’s been a patient and could identify with that experience,’ he said. ‘We’ve had some responses that have made us think that perhaps it does have a wider audience.’

The next frontier is a series of shows at the Melbourne International Comedy Festival in April, something Ingham could never have imagined until recently. He said he admires the dedication and enthusiasm of the actors, who are taking a week off work to perform, and the leadership of Yates and Dr Katrina Anderson, the show’s director. ‘It’s not easy to order around 12 GPs,’ he said of Anderson’s role. ‘We’re not used to taking directions.’

It’s been a lot of work and a huge learning curve – Ingham said he has a new-found respect for the behind-the-scenes work of directors and producers – but most of all it’s been a great way to get closer to his colleagues and share some light moments.

‘It’s great to have a whole bunch of GPs getting together for something completely non-medical,’ he said. ‘I’m really having a ball.’
Before he became a senator and health spokesperson for the Australian Greens, Dr Richard Di Natale’s work took him to some confronting places. Perhaps most intense was his work as a public health expert for the Nossal Institute on a HIV prevention program in India, a few years of his life that were coloured by some profoundly distressing moments.

‘It’s always confronting when you see a 12-year-old kid getting a needle, shooting up then giving it to his mate,’ Di Natale said. ‘They’ve got no education opportunities, no employment opportunities; you can see why these kids are turning to a behaviour that’s destructive.

Sadly, poor health standards and social problems are not unheard of in parts of Australia. Di Natale had seen troubling situations in his earlier role as a GP in the Northern Territory where he worked to help improve Indigenous health in disadvantaged areas. Dealing with such problems in a wealthy country frustrated Di Natale, and that frustration sowed the seeds of what would later become his political career.

‘People were coming in and presenting with health issues that were so obviously the consequence of a whole lot of other factors,’ he said. ‘That was when I decided I’d get a bit more active in politics.’

Despite the poor conditions, Di Natale could see the positive stories that were too often ignored in favour of ‘doom and gloom’. ‘You see a lot of really inspiring people in those environments’, he said. ‘It’s not all hopelessness.’

A legacy of Di Natale’s various roles in primary health is an understanding of and respect for the work of Australian GPs. ‘To be a good GP is a very tough gig,’ he said. ‘Much easier, I reckon, to spend your life specialising and sub-specialising, which is the trend these days.’

Providing a more effective system to help the people working in primary health better serve their patients was part of what inspired Di Natale’s career shift. As someone who had never participated in student politics, he came into the arena without any formal political alignment.

His working-class Italian family had Labor roots and Di Natale agreed with much of what the Democrats stood for, but it was after he read a book by Bob Brown that he decided the Greens were the party for him. He joined with aspirations no greater than handing out flyers at polling booths, but within 6 months he was standing as a candidate in the 2007 federal election. He narrowly missed out first time around, but was elected to the Senate in 2010.

Di Natale was a leading advocate for the establishment of a $4.1 billion dental scheme for children and disadvantaged adults, which was passed through the Parliament towards the end of 2012. While he acknowledged that many Australians might not understand why dental health warrants such spending, he said its strong links to overall health and socio-economic indicators made it an area worthy of investment.

‘It’s a huge problem because inability to access good dental care has flow-on effects to people’s health more generally’, Di Natale said, citing infection, malnutrition and cardiac disease as medical problems linked to poor dental health. ‘It also has a huge impact on people’s ability to get a job. If you’re missing your front teeth and you haven’t been able to get a denture, you go and sit for an interview, you’re automatically behind the eight-ball.’

The scheme, which will replace the existing Chronic Dental Disease Scheme in 2014, gives children between 2–17 years of age access to $1000 worth of dental care over 2 years.

In the closing days of 2012, the Greens announced a ‘reaffirmation’ of their policy platform. Some policies that had been considered extreme outside the party were re-worded, leaving some people unsure whether the party’s core values had changed. One example was a change in the party’s stated aims regarding the private health rebate. Having previously called for its abolition, Greens policy now calls for a ‘redirection of funds’ away from private health subsidisation, but no longer mentions abolition. The timing of the restructure – during the holiday season and leading...
up to an election year – prompted media speculation that it was a ‘softening’ of left-wing policies designed to appeal to centrist voters. When questioned on the issue, Di Natale said he thought the truth was ‘a bit more boring than that’.

‘We had a policy platform which had levels of details in some areas and very little detail in others. There’s an argument to try and get a bit of consistency across all our policy areas,’ he added, saying that the relatively young party had often developed strong policies based on one member’s specific area of interest. This had resulted in positions on some issues becoming quite complicated.

Although Di Natale doesn’t believe his medical background necessarily gives him a clear advantage in his area of politics, he said having real-world experience was important for people in decision-making roles.

‘I wouldn’t say it gives me an edge, but it definitely gives me a perspective that would be helpful for some of them to have,’ he said. ‘One of the most disappointing things about politics at the moment is that there are so many people who come from a very narrow political background.

‘There are far too many careerists who have spent their life in a political office without that breadth of experience.’

On the private health issue, Di Natale said he and his party believe a private health rebate is not the most effective use of public healthcare spending. ‘The question is’, he said, ‘could the money that’s being spent from the public purse be spent more efficiently?’

Di Natale said the question of how to best direct funds – in health as well as in other policy areas – is a simply a matter of priorities. The Greens support spending cutbacks in areas such as military action and offshore detention, as well as freeing up revenue from the mining tax. Di Natale said some of that money could be diverted towards healthcare.

‘This idea that there’s not money is really just a reflection of the priorities of the government of the day,’ he said. ‘We are going to present a costed policy platform, and then it’s essentially up to the people to decide whether they think the priorities are right.’

Di Natale acknowledged that his party had often been criticised for not explaining how policies would be costed, but he said a recent move granting the Greens access to Treasury would enable them to rationalise their policies in the same way as the major parties.

One of the Greens’ stated priorities is to improve the effectiveness of primary healthcare. Di Natale said he believed the establishment of Medicare Locals had the potential to coordinate primary care in a way that could provide the best outcomes for patients.

In a 2010 opinion piece published on health blog Croakey, Di Natale expressed concern that ‘we spend more on treating a Toorak resident than we do on an Aboriginal child in Tennant Creek’. Three years later, he expresses the same concern.

‘I think we’ve got a huge problem in terms of the way we direct our healthcare dollar. It’s not based on need. It’s based on access to providers, and providers are located mostly in more affluent areas.’

The Greens’ core health beliefs – that public healthcare should be universal, that socio-economic factors have a significant impact on physical wellbeing and that climate change is as big a threat as any to people’s health – are loved by some and dismissed by others as unrealistic idealism. The influence of the Greens on Australian health policy has been evident in the past few years, and whether that continues will be decided at the federal election later this year.
JOHN MURTAGH

Emeritus Professor of General Practice
John Murtagh shares memories of two of his role models.

‘Now John count the fairies that you can see on the edge of the big light.’ They were the very first words that I can recall hearing and the operating theatre light my first visual memory. I was aged 3 and a half years, and even then I was a sceptic as I concentrated on perceived images prior to lapsing thankfully into unconsciousness.

The benevolent dual anaesthetist and surgeon was our country GP, Dr Bill Tonkin. He was an outstanding man and professional who I was privileged to know for 28 years. He came to our small rural township not long before the Second World War and was obligated to serve the community in lieu of active military service. A bachelor, he was cared for by his mother and his artistic sister – the practice manager known as ‘the iron curtain’.

Dr Bill was my childhood hero. I recall a piece of fencing wire piercing my foot and two strong men could not budge it. Off to the surgery and there he was on a Sunday afternoon successfully removing the wire and offering a humbug for being brave!

Another incident involved falling out of a mulberry tree while inspecting silkworms and losing a large slice of thigh due to striking a large nail used as a foot lever. It was also skilfully repaired followed by a humbug. Then there was the dreadful memory of falling off a fence onto box thorn and spending a few hours having countless thorns removed and being painted bright yellow with acriflavine antiseptic. Any wonder my natural phobia is aichmophobia.

I also recall home visits on cold dark nights for a grandmother with bowel obstruction from colonic carcinoma and a brother who was a severe asthmatic. The same scrawny 4-month-old brother who was vomiting profusely and death seemed inevitable until Dr Bill somehow diagnosed and repaired his pyloric stenosis. I have olfactory memories of nervous visits to the surgery and the unforgettable smell of Lysol.

There was a poliomyelitis epidemic in the town and I was eventually diagnosed as one of its victims. Dr Bill initially detected pneumonia and I had the dubious distinction of being one of the first patients in Victoria to be administered sulphonamides (circa 1944). He also managed to entice an old colleague – the famous Dame Jean Macnamara, Australia’s expert on poliomyelitis – to visit Coleraine regularly to monitor the progress of the many affected children. Such was his influence.

When I commenced medical studies he was delighted, and I was privileged to be treated to many fireside chats about his experiences. I was permitted to watch him at practice and that was the beginning of my interest in and documentation of ‘Practice tips’ as I was taught several ‘tricks of the trade’.

One particular innovative procedure was the swift one-stroke removal of unwanted foreskin using a red-hot knife (possibly his pocket knife heated over a flame) – serious cauterisation! The little boy in me flinched!

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One of the local lawyers described Dr Bill as conscientiously dedicated, available, compassionate, over-cautious to the point of irritation and obsessed with confidentiality. He recounted the scandalous case when a newborn infant was found in a toilet block and Dr Bill refused to divulge any
medical information about his patients to investigators. He certainly was an interesting role model. My mother said that when I started school I insisted, with many tears of persuasion, that my hair had to be fashioned on his ‘cow slick’ style.

Several years ago when I was a keynote speaker at a conference of hospital medical directors, a smart alec asked me ‘Who is the ultimate medical practitioner?’ My answer was ‘One who can manage competently any medical contingency such as my former family doctor and Dr Bill Purton.’ The bean counters seemed bemused.

Bill Purton was an experienced Bendigo general practitioner who had a reputation for being able to undertake and fix virtually any medical problem. When I took up an appointment as a generic registrar at Bendigo Base Hospital I soon discovered that his lofty reputation was well deserved. Although not a registered specialist he enjoyed admitting rights to the hospital.

This humble and gentle GP was amazing. He could trephine a skull, open a chest and abdomen as well as any surgeon, perform a caesarean operation and generally exhibit procedural surgical skills of the highest quality. Paediatrics and complex emergencies were his forte. As relatively inexperienced residents and registrars, our catchcry when in trouble was ‘Call Bill Purton.’ I recall him supervising an exchange transfusion in a neonate, abdominal dialysis, open tracheostomy, managing the Birds respirator and other new technology.

On one occasion we had a patient with obstructive urolithiasis and no surgeon was available. Bill arrived with his own instruments (possibly a political necessity) and removed the stone.

Such iconic multi-skilled GPs are a dying breed, but I am aware of several rural and remote GPs still practising such wonderful comprehensive medicine. They are all heroes and heroines, and yes those Williams were something else.

McGraw-Hill Education has just released Australia’s first diagnostic flashcard app for iPhones and iPads written by renowned Emeritus Professor of General Practice John Murtagh.

The 560 flashcards are designed to assist medical students with patient presentations and to assess and diagnose each presentation. The app is an ideal tool for medical students in their third and fourth years of study. It is also useful for GP registrars, interns, junior medical officers and international medical graduates in their practical experience and exams.

The simple swipe and tap app enables users to bookmark, search by category, add their own personalised notes to cards, as well as reshuffle the cards.

The new app contains the experience, knowledge and expertise of one man in a single place to be shared and imparted to the future generations of Australia’s leading general practitioners.

Available from iTunes for $34.99 you can purchase the app at https://itunes.apple.com/us/app/diagnostic-flashcards-for/id573383990. Or simply scan the QR code above on your Iphone or Ipad using a QR reader.

The flashcards cover topics including:
- endocrinology
- hyperthyrodism
- neoplasia
- infections
- dermatology
- paediatrics.

Winners of Katherine Howell’s Web of deceit:
D Rankin, A Vogel-Sharman, P Rogers, S Chisolm, B Singh, L Tufts, S Stay, R Susnja, B Hoare, B Joyner.
It took Dr Christine McConnell a few attempts to find her ideal role in medicine. Raised on navy bases around Australia and trained in Victoria, McConnell decided she needed a professional adventure, so when she saw an advertisement for a year-long stint on Macquarie Island in 1990, she jumped at the opportunity. The work was interesting and the scenery was stunning, but despite being classified as part of the Antarctic, the island doesn’t get days of constant darkness and McConnell described its climate as somewhat akin to that of Tasmania. However, her subsequent 1-year stint at Mawson Station provided the full Antarctic experience.

Weeks of sunlight in summer and nothing more than twilight in the depths of winter coloured her work as a GP in the small community. Her role was both practical and administrative. Being so isolated, it was crucial that she kept the medical facilities well maintained and in stock, as well as ‘keeping an eye on the health of all the people down there, checking with them on a regular basis’.

Working in the freezing conditions had its drawbacks, but as McConnell said, it’s nothing she wasn’t expecting. ‘Part of the reason why you go there is to experience the different climatic conditions.’

After her time down south, McConnell returned to Victoria to work in a rural general practice. It was a great experience and gave her a different perspective, but there was something missing, so in 1995 McConnell decided it was time to take flight. ‘That was valuable and good as well,’ she said of her time in Victoria, ‘but I started to feel the need for something different and then I saw an ad for the Royal Flying Doctor Service (RFDS), and that was 17 and a half years ago.’

The job required McConnell to move to Meekatharra, a small mining town in Western Australia that was famously described by prime ministerial wife Tamie Fraser as ‘the end of the Earth’. With an average temperature of nearly 40°C in summer, it was the polar opposite of what McConnell experienced in the Antarctic. However, she found herself well-suited to rural life and captivated by her work as a flying doctor, which she continues to this day.

McConnell’s role sees her in the air 3 or 4 days a week. She regularly flies out to small towns to run hands-on GP clinics, as well as being on call to...
handle the emergencies and aero-medical evacuations for which the service is perhaps better known. Her non-flying days are spent working as a GP in the local hospital at Meekatharra. It’s this intriguing mix of work, as well as its importance, that has kept McConnell with the flying doctors for so long.

‘The variety of the work, I think, is the most interesting part of it because you’re never really sure what you’re going to get from one day to the next,’ she said. ‘People out in the rural and country areas of Western Australia are very appreciative of the services we provide.’

While the mining boom has created myriad jobs and benefited Western Australia’s economy, it has also had implications for the health sector. As the population of the state has grown and small towns have developed into mining hubs almost overnight, the RFDS has had to keep up. That means more doctors and more aeroplanes, which of course requires extra funding.

‘The RFDS I think works very efficiently,’ McConnell said, ‘but Western Australia is a growing state, more particularly in these remote areas with all the mining activities.’ She added that the RFDS, as a private charity, is appreciative of any help offered and that ‘more is always nice’.

Another health issue facing towns such as Meekatharra is the ‘fly-in fly-out’ nature of many mining jobs. McConnell said it is difficult to provide continuity of care to patients who are constantly on the move and might not feel they belong in either their mining town or Perth.

‘It does make it more difficult,’ she said. ‘Often we just see them for injuries and individual events. We often don’t see them enough to even think about doing chronic disease management.’

While most of McConnell’s work isn’t as dramatic as members of the public perhaps imagine – she said there’s a perception that flying doctors perform ‘brain surgery in the back of the plane’ – it can be thrilling. Being called on to deliver a baby in the middle of nowhere and then flying mother and baby back to Meekatharra is an example of how working for the RFDS can provide urgent challenges, but also an immense feeling of satisfaction when those are overcome.

In 2010, McConnell received recognition for her years of service as a flying doctor, winning the Rural Health Doctors’ Service Award for Remote and Clinically Challenging Medicine. It was an unexpected accolade, but one that McConnell was honoured to receive. ‘It’s always nice to get some recognition for what you do,’ she said. ‘It validates what you do.’

And as for small-town life? McConnell still enjoys Meekatharra and has no plans to move anytime soon, provided she can make it down to Perth for a movie and some shopping every once in a while. ‘I’m quite happy here in a smaller town’, she said. ‘I find it suits me.’
Dr John Apps’ career in wilderness medicine has taken him on some extraordinary adventures. He now passes on his skills to other doctors.

There aren’t many people in the world who can run a marathon, let alone one at nearly 5000 metres elevation through the Himalayas. Rarer yet is a doctor who can keep up with the runners and tend to them in harsh conditions if anything goes wrong. John Apps is such a doctor. Overseeing the medical services for the Everest Marathon is all in a day’s work for the British-born adventure doctor and part-time GP. ‘I stationed a number of doctors on the descent route and my job was to jog behind the slowest person,’ Apps said. ‘There’s a lot of up and down, there’s a lot of rough ground, a lot of yaks to avoid.’

Apps’ work throws a wide range of challenges his way – yaks included. Overseeing the marathon isn’t easy, but Apps said the hardest part of that job is convincing the ultra-competitive runners to take it easy while acclimatising to the high altitude. He has also provided medical support for an extreme marathon in Antarctica, where the flatness of the course is offset by the fact that, as he puts it, ‘it’s just blooming cold’.

‘You’re hauling in all these huge lungfuls of air at minus 15°C and it does take it out of people,’ he said. But there is much more to Apps’ work than the marathons. He recently returned to his New Zealand hometown of Westport after completing his ninth season in Antarctica, where he works for Antarctic Logistics and Expeditions, a private company that provides logistical and medical support to visitors, including emergency search and rescue. Clients range from ultra-fit adventurers setting off for the South Pole to elderly sightseers.
Each case presents its own set of challenges; older tourists need to be monitored for cardiac risk factors, joint problems and other issues associated with age, whereas those heading off on expeditions are at risk of trauma such as impact injuries and frostbite.

Apps recalls an incident where a climber fractured his leg in a remote area that was unreachable by plane or vehicle. He and his colleagues had to call on all of their skills and experience to get the man back to safety.

‘The rescue probably took about 4 days to complete fully because of weather conditions and difficulty with access,’ he said. ‘We basically got our little ski plane as close as we could, and then it was a matter of putting the skis on, roping up the glacier and going off to collect this person, then dragging them back on a sledge.’

There have been some incredible moments at the other end of the globe, too. Before he moved down south, Apps did similar work in the Arctic, which he considers the toughest environment he has encountered.

‘Probably the harshest place I’ve ever worked has been up in the Arctic, where it is actually much colder than the Antarctic,’ he said. ‘Although you’re at sea level, you’re actually on sea ice, so there’s an awful lot of moisture in the air. The combination of moisture plus cold really does suck it out of you.’

He tells the story of particularly memorable Arctic expedition, during which he was woken by a large piece of wood that had fallen onto his tent and just missed him.

‘One storm we lost one-third of our tents, and my tent was flattened by a piece of timber that got blown off a structure,’ he said. ‘I was quite lucky.

‘Quite literally you could not stand up in this storm. I remember crawling out of the wreckage of my tent and just being bowled over.’

Apps’ experience working in hostile conditions has taught him that wilderness medicine is as much about survival skills and teamwork as it is about medical knowledge. This July, for the third consecutive year, he and several of his colleagues will conduct a polar medicine course in the mountains of New Zealand’s South Island to share their practical expertise with doctors from around the world.

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If someone on your rope falls into a crevasse, you need to be able to know what to do instantly

The hands-on, 6-day course in the Pisa Range near Wanaka will show doctors how to apply their existing medical knowledge in completely different and adverse conditions.

‘The skills we impart are how to apply what they already know in a different environment where you haven’t got an ambulance, you haven’t got lots of nurses and a nice warm room,’ Apps said.

Some of the practical training includes dogsledding, snowmobiling, cross-country skiing, travelling on glaciers and building shelters in the snow. Participants learn how to extract patients from dangerous situations and treat them in the cold, but equally important they learn how to keep themselves safe and ensure they are a competent and useful member of the rescue team.

‘We always teach that safety is the number one, and you need to not be a liability to the team,’ Apps said. ‘If someone on your rope falls into a crevasse, you need to be able to know what to do instantly, rather than say “Oi, what do I do?”’

Apps’ fellow instructors include Dr Dick Price, an experienced search and rescue medic and Everest summiteer who Apps describes as a ‘legend’ in the field, Mike Roberts, who works as an Everest guide as well as for the US Antarctic program, and Simon Murfin, a remote nurse and medic with Antarctic experience. The course is accredited by the Wilderness Medical Society.

‘What I love to see is on about the third or fourth day, people have relaxed into their various groups and I think they’re suddenly realising the potential of what they can basically now get out and do,’ Apps said.

It’s not feasible for all doctors to find a job where they can use these skills. Apps said the combination of ‘big bills and big mortgages and kids going through school’ – none of which he has to worry about – make the travelling life of an adventure doc impractical for many. But for those who do make the leap and choose this career path, the one guarantee is that ‘another day at the office’ is never just another day at the office.

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In the eye of the storm

SHARON LAPKIN

When tragedy struck Bundaberg for the second time in 2 years, Associate Professor Brad Murphy flew into the storm to coordinate healthcare for many thousands of dislodged citizens.

Canadian astronaut Chris Hadfield, who is currently aboard NASA’s International Space Station orbiting the Earth, took a photograph on 29 January of the Burnett River in Bundaberg spilling out into the Coral Sea like lava from an erupting volcano.

The devastation down on the ground was difficult to believe. The worst flood on record had left entire streets consumed by muddy water with shiny rooftops dotting the waterscape. The sky was buzzing with choppers. They were continually taking off and landing, and for Vietnam veterans it was like being back in the war. Today, some are struggling with post-traumatic stress all over again.

Almost 30 000 people in Bundaberg and the nearby town of North Burnett lost power during the floods, which occurred on the tail of five tornadoes. The river rose just shy of 10 metres and, unlike the last flood 2 years ago, many people didn’t have time to collect their belongings or medications. They were swept up by rescue boats and choppers and moved to evacuation centres.

Associate Professor Brad Murphy, a local Bundaberg GP and founder and Chair of the RACGP’s Aboriginal and Torres Strait Islander Faculty, was away from town that weekend in Tamworth, but when he heard from family what was happening in Bundaberg he charged for home.

‘We basically skirted around the rainwaters with roads closing behind us and it was very clear to us we weren’t going to get home,’ he said. ‘We managed to get down through the Toowoomba Range going the very long way home to Brisbane. We left the car in Brisbane and flew home so we could get there and look after friends and family.’ Murphy acknowledges that going back flew in the face of conventional wisdom, ‘You don’t go into a disaster area’, he said, but ‘I was keen to make sure everything was right for us and to get involved. As a hospital board member I needed to be there.’

The storm ‘hovered over Bundaberg for the best part of 2 days and dumped a lot of water,’ Murphy said. The winds were huge and, at 150 kilometres an hour, they tore through the town.

In North Bundaberg, he added, many homes went under completely. ‘A lot of homes were swept away; we saw landslides, we saw homes disappearing into the ground’.

Many thousands of people were dislodged from their homes and Murphy worked 18–20 hours a day for 4–5 days straight as the disaster coordinator. He worked with the Medicare Local in setting up two of the four evacuation centres, and it was ‘bit by bit as things eased off and the disaster stayed settled that we went into recovery mode’.

Murphy found it challenging, as a practising GP, not to reach out to people and attend to their clinical needs, but his role as disaster coordinator was a priority. ‘The GPs were amazing,’ he said. One of the doctors whose entire practice went under in the Hinkler Central Shopping Centre ‘rallied up and ran around and did coordinated clinics in the evacuation centres for me’, he said. Full of praise for all the local GPs who worked in teams to administer clinical care to devastated patients, Murphy said that even now, with the water gone, many of those GPs who previously did not bulk bill are bulk-billing patients.
Of the four local general practices, two were lost in the flood and two of the larger pharmacies were also destroyed, along with all their prescriptions.

‘When we were running around giving out scripts for people to access their medications, we came across a big tin shed full of elderly patients from one of the nursing homes that had gone under,’ Murphy said. The home had evacuated about 108 patients and ‘some 50 of them were still in this hot tin shed’. It presented a real problem for Murphy because most of the elderly patients were on thickened fluids, but none were available. ‘A good proportion of them ended up on drips,’ he explained.

A lot of friendships, a lot of networks were created around the disaster table.

Murphy was able to work with the staff who were flown in to help coordinate the emergency services to mobilise resources very quickly, and ‘over 8 or 10 hours we managed to get all the nursing home patients relocated’, he said.

The disaster heightened people’s needs – those who were low-care need suddenly became high-care need. And some patients who were previously coping by themselves suddenly needed clinical assistance. The nature of care in the evacuation centres changed too. It was ‘interesting to watch the needs change from immediate needs and making sure people have got their pills to making sure you have respite workers in evacuation centres to help shower some of the older patients’, Murphy said.

‘I don’t know what was worse – seeing the floodwaters at such a peak and the houses going under, or the floodwaters recede and watching the mud through everything and the heartbreak of people throwing all their belongings out on to the footpath,’

Murphy said ‘A lot of friendships, a lot of networks were created around the disaster table’, between the different agencies working to deliver emergency services. ‘The army were very well received,’ he added, referring to the 200 Australian Defence Force soldiers who were deployed to help with the clean-up.

But for the locals, the road ahead is a long and difficult one. The disaster was a one in 200-year-flood that wreaked havoc only 2 years after the last flood, from which many people were still recovering. And ‘the cyclone season doesn’t start for several months,’ Murphy noted. ‘This will go on for 6 months or more because there are so many families that have been dislodged.’

Before the flood there were 200 rental homes available in Bundaberg; now there are only 40. The two caravan parks on the river that went under may never reopen, and many people lost their homes and everything they owned.

Murphy’s home suffered substantial water damage, but he counts himself among the lucky ones. Prior to the flood he was about to build a clinic on a picturesque acre of land, surrounded by 30 idyllic acres, where ‘you look out the consult window and watch the cattle graze’.

The practice, which will be a mainstream practice with a focus on Aboriginal health, will feature pergolas, hedges and gardens for outside consultations. The site has survived the last two floods and for Murphy, this is a good sign because the clinic can act as a disaster point if ‘it ever happens again’.
Consumed by technology?

Imagine the scenario. A teenage girl comes home from school, turns on the TV and settles down on the couch. With one eye still vaguely focused on the TV, she opens up her laptop to do her homework, while at the same time holding a few conversations on Facebook chat. Her iPhone rests on the arm of the couch near her head and every few minutes she checks it for messages, even though she hasn’t heard it beep. Frustrated by the lack of texts, she shoots off a few of her own, getting a little shiver of excitement with every reply and silently reproaching those friends who take longer than half an hour to write back. Dinner comes and goes – also consumed on the couch – and with the exception of a few bathroom breaks, the girl stays put until 11 pm, when her fed-up mother finally chases her off to bed. The phone is switched to silent mode, but an observer would see a bluish glow light up the room every so often throughout the night as the texts come in, and would hear the girl’s grumbles as she rolls over to reply to each one.

With the lightning-fast evolution of social technology, it’s a scenario that is increasingly becoming the norm across Australian households. According to Dr Philip Tam, a Sydney-based child and adolescent psychiatrist and president of the National Institute for Internet Research Australia (NIIRA), constantly being inundated with information in bit form is changing the way young people think, and even reshaping their identities.

‘In many ways, problem internet use is the ultimate postmodern affliction for the 21st century,’ Tam said. ‘We’re now being bombarded literally by bits and by information, which is very different from what we might call knowledge, let alone wisdom.’ He added that, in the above scenario, ‘She’s not having any time by definition to self-reflect or construct any meaningful narrative out of this. She’s just responding in almost a spinal way to tweets and updates and emails, without any deeper reflection.’

Simultaneously using multiple screens in this way is an example of what some experts refer to as ‘continuous partial attention’, where users focus on several stimuli at once, but only engage with each on a superficial level. Linda Stone, the former Microsoft
executive who coined the term, wrote that ‘we pay continuous partial attention in an effort not to miss anything’. This is now especially true for social media websites such as Facebook and Twitter, where personal information is shared, news is spread and seemingly all of life’s social events are organised.

There is an important distinction between continuous partial attention and multi-tasking, one that Stone describes as a matter of motivation. Multi-tasking, she writes, is the conscious and efficient use of time to complete a range of necessary tasks – usually menial – such as having lunch while making a phone call or packing a backpack while brushing your teeth. Continuous partial attention, on the other hand, is based on the desire to be constantly connected to the digital world and often results in poor productivity and concentration.

The problems associated with this kind of behaviour are not limited to children and teenagers. Most offices are now so heavily reliant on computers that workers are rendered useless if their system goes down. With that comes the distraction of being constantly connected to the internet and the regular interruption of emails. Tam used the archetype of the ‘lone Victorian hero scientist’ as an example of how work that used to require intense focus and single-mindedness has been affected by pervasive technology.

‘Nowadays scientists are constantly bombarded by updates, by papers, by email. It’s very hard to really make sense of a single narrative in their endeavours,’ she said, adding that ‘Writers are now talking about just being bombarded with information. They can’t even write a novel anymore because they’re responding to this. The question is’, he said, ‘Does the technology rule us, or are we in charge of how we use technology?’

Given that technology is so much a part of daily life in Australia, it can be especially difficult to know how much is too much. Experts are divided as to whether over-dependence on technology – commonly known as ‘internet-use disorder’ – should be classified as a medical condition. Tam said he has seen enough first-hand cases to confirm the similarities between this disorder and other forms of addiction.

‘To have an addiction you need to have a clinically significant impact on your daily functioning, you need to have an unhealthy obsession and you need to show what might be called tolerance and withdrawal,’ he said.

‘Gamers and problem internet users do show all of these changes. You’re always thinking of it, you’re itching to get back to your game and log on.’

Full-blown addiction can have serious consequences and is most likely to be found in those with underlying psychological issues, such as poor self-esteem or depression. It appears to take hold more commonly in those who play video games as opposed to heavy users of social media.

‘There’s no question in my mind that people who are more vulnerable to heavy use are the people with underlying general medical conditions and psychiatric conditions,’ Tam said. He added that online fantasy role-playing games ‘seem to be the most compelling, the most addictive, because you can be completely immersed in this virtual world where you don’t need the real world anymore. That fulfils all your need for excitement, for socialisation and you can play for hours, sometimes days.’

‘In many ways, problem internet use is the ultimate postmodern affliction for the 21st century.’

A strong part of the appeal of these games is that they allow the user to re-create their identity and escape their real-world troubles. ‘Even the word ‘avatar’ means reincarnation or re-embodiment, so it means a re-invention of yourself,’ Tam said. ‘You might be the puny bullied kid at school, but in the game you can adopt some big hulking muscly Nordic hero or beautiful glamorous goddess.’

The same can be said, in a different context, of how social media appeals to young people. Tam said he sees social media as a platform on which teenagers can explore and even create their own identity – something that can be healthy in moderation but harmful in excess.

‘The way I look at it is that teenagers are using social media to explore the boundaries of themselves, of pushing the limits, of exploring issues of identity and sexuality,’ he said. ‘We all are defined by what other people think of us, but ultimately it’s whether we take that to a ridiculous degree and we become a completely false image of ourselves.’

So when does enough social media use become too much, and how can we help younger generations keep their use to a healthy level? There is no simple answer to either question, and it would appear that each case needs to be assessed individually. Tam suggested that limiting children’s exposure to communication technology, at least until 5 or 6 years of age, is a good starting point. He also said that building ‘resilience’ in children by teaching them a wide range of skills – both computer and non-computer related – and encouraging them to socialise gives them a better chance of finding a balanced life. This means finding the time to be an active parent and avoiding the temptation to let the TV or computer do the work.

‘Buying them an iPad is far easier than taking the time to teach them how to swim,’ Tam said. ‘That’s the problem with a lot of parents: money rich, time poor.’

A US mother made global headlines last year when she gave her son an iPhone for Christmas, with an 18-point contract detailing how he was and wasn’t to use it. The key rules were that the phone would be switched off between 7:30 pm and 7:30 am on school nights, it would not be taken to school and it would not be used in social situations or when in conversation with others. The mother received widespread praise for her proactive approach and the obvious love and honesty with which she discussed the issue with her son.

While it appears many people have no problems regulating their reliance on technology, Tam nominated GPs as having an important role to play in helping those who struggle. He noted that GPs are generally financially comfortable, but with little free time, making their own children an at-risk group for excessive exposure to technology. Despite this, he said, GPs are likely to have a greater understanding of the problem, as they are often the first port-of-call for parents who are concerned about their children.

‘GPs are very much at the forefront, and it’s usually the parent that comes to the GP,’ he said. ‘I think GPs are well aware of it. They’re by definition well-rounded and highly intelligent people with a finger on the pulse of society.’

Although technology’s influence on our lives appears to be getting ever stronger, Tam is confident that Australians’ love for outdoor activities and sports puts us in a good position to find the right balance between reality and technology. For coming generations, that balance could be a key to getting the most out of technology without becoming controlled by it.
Vegetarian diets

Increasingly, more and more people are switching to vegetarian diets. Vegetarians follow a diet based on plant foods. There are different types of vegetarians including vegans who only eat plant foods, lacto-vegetarians who include dairy foods, ovo-vegetarians who include eggs, and ovo-lactovegetarians who include dairy foods and eggs. People choose to follow a vegetarian diet for various reasons including health benefits, environmental reasons, religious beliefs, and/or animal rights. There is also a growing movement called Meat-free Monday, where people choose not to eat meat on Mondays.

Vegetarian diets offer a number of significant health benefits. People following plant-based diets tend to have a lower body mass index, and lower risk of cardiovascular disease (including a lower blood pressure and lower LDL cholesterol), cancer and type 2 diabetes (including a lower fasting blood glucose). Much of this research comes from studying 96,000 Seventh Day Adventists in the US and Canada. It is suggested that these health benefits might arise from vegetarians eating fewer calories, less saturated fat and more fibre. Vegetarians also tend to live longer.

A vegetarian diet requires planning to ensure that nutrient requirements are met. It is important for vegetarians to have an adequate intake of protein, iron, zinc, calcium and omega-3 fatty acids. Protein sources include legumes (e.g. lentils, kidney beans, chickpeas); soy products (e.g. tofu, tempeh, textured vegetable protein); grains (including quinoa), nuts and seeds; eggs and dairy products.

Iron
Vegetarians tend to have lower iron stores than non-vegetarians, but they are not at higher risk of iron deficiency. The bioavailability of non-haem iron (i.e. iron from non-meat sources) adapts with need, and absorption is increased with consumption of vitamin C, vitamin A and beta-carotene while absorption is decreased with phytates, polyphenols (such as tea, coffee, cocoa, red wine) and calcium supplements.

Protein sources include legumes (e.g. lentils, kidney beans, chickpeas), soy products (e.g. tofu, tempeh, textured vegetable protein), quorn, seitan, grains (including quinoa), nuts, seeds, eggs and dairy products.

Zinc
Zinc is found widely in plant foods and therefore vegetarians should be able to meet their zinc requirements. Phytates, found in unrefined plant foods, can inhibit zinc absorption. However, often processing and cooking breaks down phytates, such as with soaking and cooking legumes.

Tips for vegetarians
- Eat a variety of rich sources of protein foods daily; don’t just cut out meat. Protein sources include legumes (e.g. lentils, kidney beans, chickpeas); soy products (e.g. tofu, tempeh, textured vegetable protein); grains (including quinoa), nuts and seeds; eggs and dairy products.
- Include a vitamin C rich food with your meals such as citrus fruit, tomato juice, capsicum or berries to increase non-haem iron absorption.
- Avoid phytate-containing foods such as large amounts of unprocessed bran, which can decrease absorption of iron and zinc.
- Include 2–3 serves of calcium-rich foods daily and ensure adequate vitamin D through small amounts of sun exposure.
- Screen for vitamin B12 deficiency, and if deficient recommend vitamin B12-fortified foods and/or supplements.
- Include alpha-linolenic acid (ALA) sources in the diet such as chia seed, flaxseed, canola, walnut, soybean, wheatgerm and green leafy vegetables.
- It is important to consult a dietitian about vegetarian diets for children to ensure nutritional requirements are met. Strict vegetarian diets are not recommended for babies and very young children.
Calcium sources include calcium-fortified soy, almond, rice or oat milks; hard tofu; unhulled tahini; kale; Asian green vegetables; almonds and dairy products.

Vitamin B12
Vitamin B12 is found almost exclusively in animal foods, therefore vitamin B12 deficiency is likely in people who restrict animal foods. It is essential that vegetarians consume vitamin B12-fortified foods or take a vitamin B12 supplement, especially women who are pregnant or breastfeeding.

For those taking a vitamin B12 supplement, it is more effective to take small frequent daily doses (recommended daily intake) versus large infrequent doses.

Vitamin B12 sources include dairy products, eggs, fortified soy or rice milk, fortified vegetable sausages, burgers and Marmite. Mushrooms contain a small amount of vitamin B12, but not sufficient to be a good vitamin B12 source.

Omega-3 fatty acids
Vegetarians tend to have lower levels of the omega-3 fatty acids typically found in fish, eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA). ALA is converted to EPA and DHA, but the conversion process is inefficient.

EPA and DHA sources include eggs, microalgae and breast milk, ALA sources include chia seed, flaxseed, canola, walnut, soybean, wheatgerm and green leafy vegetables.

A dietitian-nutritionist can provide advice on how to ensure nutritional requirements are met while following a plant-based diet.

Do I need to cut down on my dairy foods, doc?

Based on the latest NHMRC Australian Dietary Guidelines, eating 3 serves of any milk, cheese or yogurt products a day is associated with reduced risk of hypertension.1

Unfortunately, 8 out of 10 Australian men have fewer than 3 serves of dairy foods each day, so they miss out on this benefit.2

Remind your patients to cut back on ‘extra’ foods (energy-dense, nutrient-poor) and enjoy 3 serves of dairy foods, such as milk, yogurt and cheese, every day.

To find out more and to order patient resources, visit www.dairyaustralia.com.au/GPnutrition

2. Doidge JC & Segal L. ANZJPH 2012;36(3):236–40 and additional personal communication. © Dairy Australia 2013. All rights reserved. Wellmark DAA22185 03/13
Want to know more about the ‘eHealth record system’?

The RACGP is about to embark on a comprehensive campaign to inform GPs about the ‘eHealth record system’. The National E-health Transition Authority’s (NEHTA) Clinical Lead, Dr Nathan Pinksier, said the ‘eHealth record system’ – which was formerly known as the Personally Controlled Electronic Health Record (PCEHR) system – is gaining popularity among Australians, with 70,000 joined up so far and ‘significant registrations appearing on a regularly basis’.

GPs who’d like to learn more about the eHealth record system – including how to create high quality shared health summaries, when and what to upload and how to access patients’ summaries – can attend free education seminar programs at locations across Australia. The seminar programs will be run in cities, country towns and remote locations, and will commence in April and run through May and June. GP registrars, practice nurses, practice managers and other staff are also able to attend.

The program will be conducted mostly out of hours and will be face-to-face for 2 hours. For GPs who cannot get to the seminars, they will be available as online webinars through the College website. And for those without internet access, the RACGP can post them a USB with a video and PowerPoint presentation, which they can watch while participating in a conference phone call.

Pinksier said there would be about 200 events over the next 3 months with about 30 GP clinicians presenting the material to their colleagues across the country. The seminars ‘will outline the process so people are much more confident making a decision’ to use electronic health records, he said.

‘It’s a new system; every new system needs bedding down’, Pinksier added, acknowledging that GPs might be hesitant to get started on creating electronic health records. But he stressed the success of electronic health records in the Northern Territory. ‘When you talk to GPs in the Northern Territory’, he said, ‘they say “It’s really important to my work and I need it to continue”.’

Pinksier is confident that the eHealth record system will continue if there is a change of government at the upcoming federal election. Both the current government and the Opposition are committed to developing electronic health records, he said, but under a new government of either major party there could be some restructure of the system. ‘In 5–10 years it may look a bit different, but it is going to continue in one format or another,’ he added.

Registrations are now open for the education seminars ‘Using the eHealth record system to add value to clinical consultation’. For more information or to register, visit www.racgp.org.au/yourpractice/ehealth/ehealthrecords/pcehr/seminars.
Global *postcards*

**Hidden gem: Mutton Cove, New Zealand**

Located in the Abel Tasman National Park at the northern tip of New Zealand’s South Island, Mutton Cove is a haven for those who love their picturesque beaches without the tourists. To get there from Takaka, the main town in the area, takes about an hour’s drive along a sealed and then very much unsealed road, followed by a 2-hour scenic walk through a temperate rainforest and along pristine coastline. Save for the occasional passing trekker, you’re unlikely to be disturbed by anyone.

For nature-lovers, a special treat awaits at the cove’s northern end. Swim to the rocks about 50 metres out, climb to the top and you’ll find yourself looking across at a wild seal colony. If you feel the urge to swim closer to the seals, make sure you stay away from the young ones; their mothers can be very protective. Otherwise, it’s easy to spend hours just watching them swim, waddle across the rocks and call out to each other.

**Appy holidays: Camera+**

As smartphone camera technology continues to improve, travelling with a point-and-shoot is becoming less and less popular. Apps such as Camera+, which has a range of features to enhance the quality of photos taken on an iPhone, will do nothing to stop that trend.

Camera+ comes with 16 scene modes including ‘clarity’, ‘portrait’, ‘sunset’ and ‘night’ to best capture any moment, as well as adjustable exposure settings, enhanced zoom and touch focus. The app’s editing software allows users to touch up photos after they’ve been taken by adjusting tone, white balance, detail, alignment and other variables. There are also some pre-set effects that can be applied to photos individually or in layers.

It’s no replacement for an SLR camera, but Camera+ can add a touch of class to quick travel snaps. It is currently on sale for US $0.99 and has a 4.5/5 star rating on the iTunes website. The app is compatible with iPhone, iPad and iPod touch.
Comparing backpacks

For those travellers constantly on the move, a backpack can be more practical than a standard suitcase. There are several popular styles of backpack, each designed for different purposes. Hikers typically use a rucksack, a long, thin type of backpack that opens from the top and holds between 55 and 75 litres. Rucksacks have padded shoulder, chest and waist straps that are designed to spread weight evenly, making them as comfortable as possible to carry over long treks. Nowadays, most rucksacks also open from the front like a suitcase for easy access.

Backpackers moving from place to place, but not doing any major treks, are best off with a travel pack. These are shorter, wider and deeper than rucksacks and are designed for practicality when living out of hotels and hostels. They open like a suitcase, usually have several organiser pockets and most noticeably come with a detachable 15–20 litre daypack, which is convenient to use in cities and for day trips. Travel packs are designed for getting from hotel to hotel, not for walking long distances.

Hybrid ‘wheelie’ travel packs – with wheels and a handle as well as backpack straps – are available. They can be useful when travelling in well-developed countries, but are a nightmare on uneven or unsealed roads. It’s worth remembering that these bags are generally more expensive and a lot heavier than other travel packs.

Australian brand Black Wolf has a range of good quality backpacks at very reasonable prices. For those wanting an Australian-made product, One Planet offers a range of top quality backpacks, some of which are endorsed by the Chiropractors’ Association of Australia.

Flickring your memories

If you want to share your holiday snaps or video with family and friends while you’re away, Yahoo’s Flickr is easy, accessible and immensely versatile.

Simply create an online account, select whether you want to share with only your family or with your friends as well. If you’re not concerned about privacy, leave your photos or video on public view. If you chose to leave them on public view, but are a little nervous about your privacy, use a pseudonym and share that name with your family and friends.

The next step is to upload your photos to your photostream. Write a description and anything else you’d like to say about them. Tag them and select your location from the map. Tagging and pinning the location helps people find your photos, but if that’s not a priority don’t do this. There is a comment function on all photos on your photostream that allows people to communicate with you, and you with them. There’s also Flickr mail for longer or more personal messages. You can set your account to send you an email when somebody comments on your photos or sends you a message.

Flickr is free-of-charge for uploading two videos and 300 MB of photos per calendar month, but a ‘Pro account’ is available for more serious users. It costs about $24 per year and allows unlimited uploads of video and photos, the ability to show HD video, and unlimited storage and bandwidth.
A Californian designer's fear of IVs inspired her to make hospitals more welcoming for children.

California-based Ashley Ludwin figured that if an adult like herself was afraid of being attached to an IV, the experience could be positively terrifying for ill children who spend time in hospital. Having worked in the fashion design, an industry that satisfied her creativity but not her desire to help others, she realised her skills could help brighten the lives of hospitalised children. Then she came across a 2006 study from the University of New Mexico, which found that adding simple decorations to otherwise bland equipment, such as syringes and IV bags, significantly reduced the fear and aversion children felt around those products. It was this series of events that led her to establish her own company – Little Love Medical – and create IV Decals™, a range of decorations for IV bags designed to appeal to girls and boys of all ages.

'With my love and knack for design I began dreaming of completely transforming children's hospitals into magical places, and eventually toned it down to practical products,' Ludwin said. 'I focused on IV bags because of my intense fear of IVs and after a good 6 months of product development, IV Decals were born. So I quit my job, took my savings and launched Little Love Medical.'

Designing and producing the stickers was the easy part for Ludwin. It was getting approval from the US Food and Drug Administration (FDA) that caused the biggest headaches. She'd had no previous medical background, and sifting through pages of fine print jargon was testing. There were also fees – some expected, some unexpected – and a presentation to the FDA's decision-makers before approval was finally met.

'Truly, the hardest part was not giving up in between paragraphs of regulations and multiple surprise fees,' Ludwin said. 'After 90 days of pacing around my little apartment, the FDA deemed IV Decals as a product not needed for extra evaluation and therefore able to be used on IV bags.'

The reaction Ludwin has seen from patients to the IV Decals has affirmed what she read in the research paper from 2006. She said the decorations have helped create a connection between children and the 'normally scary and sterile product'.

'The patients who have used IV Decals absolutely love them,' she said. 'They enjoy the process of choosing what colour and design they want for that day and it helps ease their fear of the product itself. For patients staying in the hospital for a period of time, their IV bags become an extension of themselves and so we want them to style and improve them in a safe and fun way.'

IV Decals is the only product released by Little Love Medical to date, but Ludwin said there are plenty more ideas in the works. These include accessories for IV poles, hospital beds, wheelchairs and walkers – all of which could contribute to Ludwin's original vision of making the hospital ward a little bit magical.

Private practices and hospitals can order IV Decals online at wholesale price and Little Love Medical ships to Australia. The company donates 5% of its profits to the American Cancer Society. Visit www.littlelovemedical.com to learn more.
This unique education program will bring you up-to-date with the most common clinical presentations, run nationally and commencing in April 2013.

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