LeaD Story

Liz Marles: leading the way

SHARON LAPKIN

RACGP President Dr Liz Marles talks about her love of general practice and being at the helm of the College for the next 2 years.

Talking to Dr Liz Marles about the role she took over last October as president of the RACGP, it becomes obvious she’s both a highly gifted communicator and a steadfast advocate for GPs and their patients. But there’s so much more to the quietly spoken and manifestly intelligent woman who is now leading the RACGP. She exemplifies what Jack Welch, the chemical engineer and charismatic former chairman and CEO of General Electric, once said: ‘Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others.’

After serving as RACGP vice-president for the past 2 years, and a national council member and chair of the NSW and ACT Faculty since 2008, Marles moved into her new role with confidence. As chair of GP Unity NSW and a member of the GP Council NSW, she was already advising the NSW Health Minister on healthcare. And as a board member of General Practice Education and Training (GPET) and chair of its Prevocational Training Advisory Committee, she was adept at working for GPs on the ground, at the coalface of general practice.

For Marles, the privilege of leadership is an opportunity to make general practice a profession of choice for graduates and to further develop an academic basis for general practice. She also wants to continue the profession’s successful lobbying, which has seen it squarely on the radar of state and federal health ministers and politicians.

Her commitment to develop the profession goes hand-in-hand with a desire to make healthcare more equitable for all Australians. ‘I would like to see those people in Australia who currently have difficulty accessing healthcare to have better access to higher quality healthcare,’ she said, adding that she wants the Australian public to see general practice as something it needs. Marles also said she’d like GPs to feel empowered about leading the future of primary healthcare and she intends to work so that ‘our ability to care for our patients in a continuum improves, rather than fragments’.

Medicine, interestingly, was an indirect route for Marles. Her first love was science and she graduated from The University of Melbourne as a secondary school science teacher. Naturally, many of those skills have served her well as a primary care doctor, a GP supervisor and an unflinching lobbyist for the profession. And while her love of science has accompanied her on her journey to becoming a doctor, it has also reinforced her belief that evidence-based research is a necessary foundation of the profession.

Marles said she first started speaking out and putting her hand up in her registrar training. ‘I was given some fantastic opportunities,’ she said. As a registrar liaison officer she loved the collegial discussions, the problem-solving and the workshops she was asked to present at. ‘I don’t think I ever decided that this was what I was going to do,’ she said, about her leadership roles. ‘I guess I’m the sort of person who can’t stay quiet!’ But she also believes that GP leadership is dependent on good mentorship. >>
Lead Story

‘I was very lucky to have a couple of key mentors,’ she said, adding that Professor Michael Kidd, who was her academic supervisor at The University of Sydney between 2000 and 2001, became an important mentor. ‘He really encouraged me to just get out there and have a go.’ In fact, Professor Kidd persuaded her to submit an abstract to a Wonca conference and, as a result, Marles attended her first Wonca conference as an academic registrar. ‘I’ve really valued his support’, she explained, adding that he’d also encouraged her to take on a GPRA role on the GPET board when the board was first setting up.

Another important mentor was well-known academic and Professor of General Practice at The University of Sydney, Simon Willcock. ‘Way back when I was an intern, I went to Hornsby Hospital and the Director of Clinical Training was Simon Willcock,’ Marles said. ‘He was really encouraging about taking on some leadership roles, but also very grounded about being a GP and how valuable that is.’

While the encouragement provided by her mentors was essential in her development as a strong leader, there were other reasons Marles stepped into the RACGP president’s shoes with such ease and grace. Her parents, who were both great role models and trail blazers, loved academic conversations and encouraged their children to not ‘just sit there and complain about the world’, but ‘to actually go out and do something about it. We were all raised like that,’ she said.

Marles’ mother has had a great influence on her life. Appointed the first Commissioner for Equal Opportunity in Victoria in 1977, Faye Marles is a strong woman who cares deeply about social justice. She remained commissioner until 1987, when she left to establish a consultancy specialising in dispute resolution and human resource management. As a lecturer in social work at The University of Melbourne since her twenties (with time off in between for marriage and a family) Faye Marles was elected to its council in 1984. She became deputy chancellor in 1986, and in 2001 was appointed the 18th chancellor of The University of Melbourne.

Faye Marles’ tremendous achievements were applauded by women everywhere, especially her daughter who was developing into a dedicated GP and lobbyist for her profession. Liz remains her mother’s greatest admirer, and has just got used to the idea that she retired a few years ago at 80 years of age.

Her father, Donald Marles, was headmaster at Trinity Grammar School in Melbourne, and prior to that he was a teacher at Geelong Grammar School where his family lived on campus. In fact, Donald was Liz’s maths teacher and taught her in her final year of school. He had and still has a great love of intellectualism, she said, ‘When we had family dinners we’d all sit around the table and there were always lots of arguments around political issues; it was always a very lively affair.’

Liz’s brother Richard Marles is the Federal Parliamentary Secretary for Pacific Island Affairs and Parliamentary Secretary for Foreign Affairs. A former lawyer and now a popular MP for Corio, he secured more than 51% of the primary vote in his electorate at the 2010 federal election. Respected by both sides of politics, Richard has a great love for science and, with a degree in law and another in science, he has a strong academic base for his passion.

You really need to get people talking to find out who they are; a trusting relationship is at the core."

Last September, together with his colleague Karen Andrews, Richard launched the group Parliamentary Friends of Science, ‘to strengthen links between the scientific community and parliamentarians and increase engagement between the two’.

Not surprisingly, there are other high-achievers in the Marles family. Elder sister Victoria is a former Legal Services Commissioner for Victoria and a current CEO at Trust for Nature. And sister Jenny is an academic in the School of Business at the University of Technology in Sydney. With special interests in the not-for-profit sector and intellectual disability services, Jenny – like the rest of her extraordinary family – is devoted to intellectual debate and the exploration of ideas.

A propensity for hard work and social justice issues, a love of science and the ability to work across political divides is a common trait of the Marles family, and Liz brings these same qualities to her role as president of the RACGP. And for those who know her professionally, it’s clear that she brings a little extra.

President-elect of Wonca Professor Michael Kidd, Marles’ academic supervisor, as noted, was also there mentoring her when she was appointed the registrar member of the GPET board. As an advocate of developing leadership skills by ‘gaining practical experience in being a leader’, Professor Kidd said he ‘spent considerable time discussing governance and policy and strategy, and ways to be effective in a role where Marles needed to ensure that the voice of the registrars was being heard’. He said she ‘did a great job and proved herself’ in the role.

Professor Kidd added that ‘Liz is a caring and knowledgeable GP with sound experience as a clinician, teacher and researcher’. He said he was confident Marles current experience as a GP at the Redfern Aboriginal Medical Service would enable her ‘to ensure that the RACGP becomes even more effective as a strong participant in ensuring improvements in Aboriginal and Torres Strait Islander health and tackling continuing disparities in morbidity and mortality’.

According to Marles, she ‘will always still be a GP’, despite her many leadership and lobbying roles. It’s clear speaking to her that she loves general practice, and it becomes increasingly apparent that her patients’ needs are as important to her as the meeting she had with the Health Minister earlier in the day in Canberra. ‘I really enjoy the opportunity to talk to people one-on-one, to get to know them,’ she said. ‘It’s such a privileged position to be the person they bring their problems to.’

For Marles, being an effective GP means getting to know her patients well because knowing their personality type is intrinsically linked to understanding their history.

Not one to be daunted by seemingly difficult consultations, Marles sees the challenges of heartsick patients as opportunities. ‘They’re the patients who, if I can get them to think a little differently, I know I can actually make a big change in their health,’ she said. ‘You really need to get people talking to find out who they are; a trusting relationship is at the core,’ she explained.

Another aspect of general practice important to Marles is continuity of care. With many GPs choosing to work part-time and the potential for patient care to become fragmented, Marles said practices need to consider continuity of care when setting up for business. Effective handover, a team approach and selecting one member to own the management issues for each patient are the components that constitute continuity of care, she said.

Marles, who has been an RACGP member since 1994, wants to build the profession during her term. She wants to support GP supervisors, increase training places and
financially reward practices that implement continuity of care for their patients.

The new RACGP president appears to have the minister’s ear. After two meetings with Tanya Plibersek in a week, Marles said the minister is very ready to listen, interested in the solutions coming from the profession and wants to work with GPs. However, Marles said, it is an election year and there may be a change of government in September.

‘We’ve had lots of good conversations with Dr Andrew Southcott’, the Shadow Spokesperson for Primary Healthcare, whose medical background provides an added insight, Marles said. ‘Peter Dutton has flagged that there’s potentially money to be saved in administration. We need to be talking with him so that if there are going to be savings they aren’t going to impact on our ability to provide the high quality care we want to.’ Marles is more than ready, she said, to work with any incoming government to ensure general practice is on the agenda.

An expert communicator, Marles punctuates her conversation with warm and generous laughter. Genuine concern for people accompanies her whip-smart intellect, and it’s no accident that her past mentors and professional colleagues have become steadfast admirers. Former RACGP president Dr Eric Fisher said Marles ‘has a wealth of life experience’ – as a former science teacher, and ‘being involved in a teaching practice and an Aboriginal medical practice’, he said, ‘she is at the sharp end of generalism that is looking after the whole person.’ Fisher added that her approachability, ‘willingness to listen, as well as an acute social awareness, will stand her in good stead as she leads the College in its endeavour to make general practice more relevant to the 21st century.’

With the RACGP in such strong hands, the next 2 years are bound to be a time of meaningful growth for general practice with an emphasis on education, research and science. And science – as Carl Sagan said – ‘is a way of thinking much more than it is a body of knowledge.’
The doctor of the House

When Liberal MP Dr Mal Washer left medicine to go into federal politics, he didn’t know that his office in Parliament House would end up doubling as a consulting room for fellow politicians of all persuasions. But that’s exactly what happened after the 2010 election resulted in a hung parliament.

Washer, the hard-working member for Moore in Western Australia since 1998, took on the role of ‘doctor of the House’ as well as his normal paid job as an MP. Having kept up his continuing professional development and registration, Washer found his GP skills were in dire need during the 18 weeks a year that parliament sits. The politicians who walk the corridors of Parliament House in Canberra are his patients, and he sees them for free in his office in between his regular job as a member in the House of Representatives.

It all started when caretaker prime minister Julia Gillard and Opposition Leader Tony Abbott won 72 seats each at the last election. After much negotiation, Independents Tony Windsor, Rob Oakeshott and Andrew Wilkie and the Greens’ Adam Bandt threw their support behind Gillard to give her the needed 76 seats to form a Labor government. This arrangement resulted in a hung parliament, in which members could not leave when the House was sitting unless they had a pairing arrangement organised by their respective party whip. This was essential to the business of government because if the Speaker calls for a division of the House, so that a vote can be taken on a Motion or a bill, and a single MP is absent it can change the outcome of the vote.

On a personal level, when any member of the lower House is ill, or needs to see a GP, it is generally difficult to organise a pair so they can get to a medical appointment. And if they do, they can be away from the House for a number of hours. It’s much easier for everybody to have a doctor in the House, and Washer is happy to assist where his expertise is needed. He doesn’t allow his political allegiance to influence the kaleidoscope of parliamentarian patients he sees. Whoever is in need of his medical care receives his undivided attention — from senators to Greens, to Independents and members of the Labor Party as well as his own party, the Coalition.

Washer has always been a vocal MP, and has exercised his conscience when he felt it was necessary. As a member of prime minister John Howard’s government he disagreed with his colleagues’ stance against stem cell research and he wanted to ban donations from tobacco companies. He fought very hard when the entire Coalition cabinet decided that children under 16 years of age needed parental consent to go and see a doctor.

‘I told them’, Washer explained, “that is not going to happen; you will change and back down,” and they said “But it’s been through cabinet and we don’t back down.” I was pretty determined and I wasn’t going to retreat,” Washer added. ‘It was non-negotiable.’ As history shows, the doctor won the debate.

I went into politics to represent Australia, not the party.

In June last year, Washer momentarily crossed the floor of the House to vote with the government on Independent Rob Oakeshott’s border protection bill. Then, after much heartfelt discussion, he changed his mind and voted with the Coalition. He later told ABC radio that he’d offered to vote with Labor if his support was needed to pass the bill to send asylum seekers to Malaysia. But then he changed his mind because he thought the bill would not get through the Senate.

Washer also called for a time-out when Labor MP Craig Thomson, a former union official, was being grilled in Parliament by the...
Coalition about his involvement in the troubled Health Services Union. ‘Obviously, there are political implications and they should be addressed,’ he said, ‘but when it comes to personal vilification day after day, week after week ... We’ve got a duty of care to people as human beings.’

As a long-time advocate of healthcare before politics, Washer has sometimes found himself on rough ground when following his conscience, rather than the party line. ‘I went into politics, he said, “to represent Australia, not the party” – and this has been Washer’s guiding principle throughout his almost 15-year political career. Well known as an MP who treats each issue on its merits and who is willing to cross the floor and vote with the other side, Washer sees himself as a ‘small “l” Liberal’ who is sometimes at odds with the more conservative members of his party. But he wouldn’t have it any other way. He sees the Liberals as the only party that would allow him the freedom to disagree with its party line when his conscience dictates.

On his career in politics, Washer said ‘It’s had its good times and bad times. There’s times I feel I’ve done a lot, and constructively; if I hadn’t been there things would not have happened’. The doctor was referring to the stem cell debate, women’s rights and many other issues on which he worked hard to add a voice.

Before politics, Washer was a successful medical entrepreneur. As a GP in the 1970s, he established Seacrest Medical Centre on the outskirts of Perth. It was Australia’s largest single private primary care facility, and well ahead of its time. Washer included other health services and a pharmacy, which made it a one-stop shop before the idea of integrated services gained prominence. ‘I had 29 doctors working for me,’ he said, and ‘We used to see well over 2000 patients a week.’

Washer bought into other centres as well, but eventually he found the administration plus practising medicine and supervising registrars was too much. ‘I would have been booked out at any one time weeks in advance,’ he said. After 25 years, Washer explained, he was ‘getting tired’ and asking: ‘Why am I doing this?’ So, true to form, he decided to be ‘fair to myself, my family and my patients,’ and move on from medicine. Or at least he thought so.

Closing the door on his political career is only a prelude to opening a window for a man who sees the world as full of endless opportunities. Washer has a couple of avocado farms and a big, fast boat with a capacity for deep sea fishing, which he said ‘I hardly ever get on’, due to being so time poor. But it’s obvious Washer won’t stop for long. ‘I have not been employed for 40 odd years by anyone else,’ he said. ‘The only guy who’s ever going to employ me is me.’

Washer’s departing wish is that the Coalition wins the next election by a big enough majority not to have a hung parliament. ‘That’s been a disaster in reality,’ he said. ‘Let’s hope that whoever wins – and my hope is the Coalition wins, naturally – that we win in a big enough way to run the country where we think of the country, rather than petty politics.’

Whatever Washer is doing after the next election, he will be extremely glad he isn’t travelling regularly to Canberra from WA. With the 3-hour time difference during daylight saving he leaves home at 3 am to get to a breakfast meeting on the eastern seaboard. ‘I spend an average of 7 hours travelling each way,’ he said. Living an hour from the airport, with a stopover in Adelaide and a half-hour drive after arriving in Canberra, it’s been a long commute to work!

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Would you like to present at the next RACGP conference?

Have you ever thought about presenting a short paper or running a workshop session at one of our conferences? Here’s your opportunity ...

Presenting a paper or running a workshop is an opportunity to develop your own skills in an academic context. It’s also a great way to connect with colleagues and engage in thoughtful, challenging discussions in a supportive environment.

GP13 will focus on six streams, which were created from feedback at GP12 and member surveys. These streams will be: Dermatology, Clinical skills across general practice, Musculoskeletal medicine, Pain management and chronic conditions, Education and training, and Business in practice.

There will also be two active learning modules each day and three plenaries over the course of the conference.

The GP13 convenor is Associate Professor Brad Murphy. He is chair of the RACGP’s National Faculty of Aboriginal and Torres Strait Islander Health, and the conference will focus on health, as well as Indigenous e-health and rural health.

Abstract submissions must relate to one of the six streams listed above, and an easy-to-follow template and instructions are available online at www.gpconference.com.au.

For any queries or advice about your abstract submission you can telephone Lisa Ryan in the national office on 03 8699 0575 or email lisa.ryan@racgp.org.au.

The College has compiled a list of reviewers and every submitted abstract will be peer-reviewed by at least two of these clinicians.

Abstract submissions opened on 11 February and will close on 14 March 2013. So there’s still time to get yours in!

Veteran investigative journalist Jeff McMullen, of 60 Minutes fame, will be at the academic session – the William Arnold Conolly Oration – on the Wednesday night before the main business of the conference kicks off. McMullen, the recipient of three honorary doctorates and an Order of Australia, is well known for his work with Aboriginal and Torres Strait Islander peoples.

About 1000 people, including more than 900 GPs, attended last year’s RACGP annual general practice conference on the Gold Coast. This year, the Darwin Convention Centre will be the venue for GP13 and three action-packed days of listening, learning and making meaningful connections. You could choose to stay a few extra days too and take some time out after the conference to explore the colourful, tropical gateway to the Australian Outback.

The Darwin Conference Centre is a multi-award-winning venue in the Darwin Waterfront precinct. Perched on the edge of the Arafura Sea, it is connected to the precinct by a series of boardwalks cantilevered over the water. You can walk to cafes, restaurants and hotels over the boardwalk, and if you have time there’s a 4000 square metre wave lagoon with 1.2 metre high waves nearby, a seaside promenade, lush gardens and a beach. You’re also directly linked to the city centre by a dedicated skywalk.

There are more than 15 apartments and hotels within 5 kilometres of the conference centre and a plethora of research institutes in Darwin including the Menzies School of Health Research, the Lowitja Institute and the Arafura Timor Research Facility.

For relaxation there’s the open-air Deckchair Cinema on the waterfront, many indigenous art galleries and museums, the largest market in the Territory at Mindil Beach (best on Thursdays) and dozens of tours and harbour cruises to choose from.

There are many reasons to get involved and present a paper at the 2013 RACGP conference. But if presenting isn’t what you want to do this year, make sure you mark the days in your diary and come join in the fun and learning. Registrations open in May.
Tackling football

To be a good GP requires two things: an interest in people and an interest in medicine. To be a good GP in Australia you could add a third requirement: an interest in sport.

When I arrived in Melbourne in 1988, I discovered almost immediately that people here have such a devotion to brutal competitive encounters that an allegiance to one team or another is essential. ‘New to Oz, eh Doc? Been to the footy yet?’ was how many patients introduced themselves. ‘Oh, er, not yet, actually,’ may have had the merit of honesty, but the words would settle between us like a snood on a candle, snuffing the tentative flame of connection between patient and doctor. Something had to be done.

My sister-in-law Penny came to the rescue. ‘We’re going to a footy match tonight,’ she announced one wintry August, ‘the teams are Melbourne and Collingwood – you’re barracking for Collingwood.’ So I dutifully trotted off to the MCG and quickly got into the spirit of things. True, my cries of ‘great catch!’ and ‘you’ve got to be kidding, ref!’ drew some quizzical glances from adjacent supporters, but once they spotted the 190-centimetre beanpole in the black and white beanie who was yelling and flapping like a badly dressed stick insect overdosed on decongestants, they took the only prudent course and ignored me completely. As did Penny.

The evening was an unqualified success and Collingwood has been ‘my team’ ever since.

As any die-hard Magpie supporter will tell you, love of The Club is an all or nothing affair. Confession time – I am neither nothing nor all. I belong in that murky territory, abhorred by any true sports fan, of the vaguely interested. To continue the confession, I admit that it is 15 years since I attended a live footy game; I admit to only being able to name Nathan Buckley and someone called Dale, or Dane, possibly both; and I admit that the start of the footy season doesn’t find me tingling with anticipation and checking the AFL draw, but only checking the drawer where I keep my wooly socks.

I am to footy what my dog is to walking at heel: uncommitted, un-passionate, but with a sense of reluctant obligation. To make my working life bearable, I used to resort to deceit. So whenever a patient enquired, ‘What did you think of the game on Saturday, Doc?’ I would invariably reply, ‘Buckley was good, wasn’t he?’ I chose Buckley because a) he usually seemed to play and b) he usually seemed to be quite good. This apparently intelligent analysis of the game seemed to satisfy the aficionados, and the consultation could proceed.

Recently, though, I have noticed a change. Fewer of my patients bother to enquire these days. Maybe they’re just being polite, sensing after years of my idiotic and repetitious responses that meaningful conversation can probably be found in alternative topics. Come to think of it, I do seem to be being required to opine on road congestion with depressing frequency. Or maybe the patients have self-selected, so that the fanatical footy followers have quietly defected to better informed GPs, along with anyone who came to me asking about HRT or spondylolisthesis (take that, spellcheck!).

Somehow, despite my failure in the third domain of interest to be a good GP – my inadequacies in the arena of footy enthusiasm – I still seem to have a viable practice. Maybe, as Meatloaf sang tunelessly at the 2011 Grand Final, ‘two out of three ain’t bad.’

*Didn’t we play in that one?*
Dr Ken Wanguhu

Born in Kenya and having worked in some of the most challenging areas of Africa, Dr Ken Wanguhu’s move to rural South Australia was a dramatic change of lifestyle.

Practising medicine in third-world areas requires a broad set of skills and a positive attitude – qualities Dr Ken Wanguhu has in abundance. The GP spent more than a decade in Kenya, Somalia and South Africa working in fields ranging from anaesthetics and obstetrics to emergency medicine. Much of his early work was in refugee camps and overcrowded hospitals, where the ‘medical facilities and the staff are very stretched’ and doctors were ‘more disease-focused rather than patient-focused’.

Perhaps more confronting still was his experience as a locum in South Africa’s KwaZulu Natal province – a region where violence and HIV were endemic following the apartheid years. Wanguhu recalled working long shifts in wards where as many as 80% of the patients were HIV-positive and the peril of gunfire was a daily threat.

Far from being overwhelmed by what was happening around him, though, Wanguhu got used to saving lives in hostile conditions and maintained a remarkably positive outlook. Being fired at by weapons while working was something he was eventually able to take in his stride.

‘I wouldn’t do it now, not for all the money in the world because now I’ve got a wife and children so that makes you see things very differently.’

Life nowadays couldn’t be further from what Wanguhu experienced as a younger doctor. In 2001, with a 3-month-old son and a daughter on the way, he was recruited by South Australia’s Rural Doctors Workforce Agency (RDWA) and moved with his family to the Riverland town of Waikerie – population 2716. Being accepted into a small community can be daunting, especially when coming from overseas, but Wanguhu has only positive things to say about his professional and personal transition.

‘Honestly, my move here was unbelievably nice,’ he said. ‘I had a very supportive community, a very supportive practice. I never felt isolated or anything, and my family was accepted.’

The people of Waikerie were expecting the Wanguhus’ arrival and banded together to welcome their town’s first African residents. They threw a welcome party to showcase the Australian way of life, but also asked Ken and his family to speak to them about life in Africa.

‘Students keep me up-to-date. They make me look at things; they teach me what is new.’

‘It was a two-way thing. It wasn’t just us learning about them, it was them learning about us as well,’ he said. ‘I think that’s what multiculturalism is about. It’s not just taking the Australian way of life because the Australian way of life has a lot of other things that have influenced it.’

Wanguhu was fortunate in that his medical training in Kenya was very similar to the Australian style of training, so his qualifications were recognised quickly.

Letters

Interested in providing feedback on Good Practice?

Please email your letters, including your name, title, address and office-hours phone number, to goodpractice@racgp.org.au or post to Editor, Good Practice, The RACGP, 100 Wellington Pde, East Melbourne, VIC 3002.

Note: letters must be under 200 words and may be edited for clarity and space.

Photos

This page: Dr Ken Wanguhu; p 11: Ken with son Kijana, daughter Lerrato-Mae and wife Susan.
when he moved. Many other international medical graduates (IMGs) have a more difficult time, and Wanguhu now works to smooth their transition as the RACGP’s rural censor and the IMG representative on the College’s Rural Faculty Board. He also sits on the RDWA board and is impressed with how the support provided to IMGs has improved. It’s not easy to find a compromise though.

‘It’s a real problem. You’ve got doctors here who are coming in, and we want to be really nice and kind to them and make their life easy, but we also want to make sure they are actually good enough to work here,’ he said.

‘We are sending them to areas where they don’t have supervision … they are isolated, so they really need to be pretty good and be able to work independently.’

Wanguhu is a generalist at heart – his qualifications in obstetrics, anaesthetics, emergency medicine and even accounting attest to that. He sees medicine as a continuous opportunity to learn, and also as a chance to pass his knowledge on. His motivations are noble but, he admitted cheekily, also conveniently self-serving.

‘I have a real interest in teaching doctors because I want someone to take my place,’ he said with a chuckle.

‘Once you’ve done medicine as long as I have you’re in auto-pilot and you don’t think about things,’ he added more seriously. ‘Students keep me up-to-date. They make me look at things; they teach me what is new. They actually teach me a lot.’

Even with all his other interests, Wanguhu nominated the day-to-day work of general practice as the best aspect of his career. He described himself as ‘not a city sort of person’ and is content with rural life and practice, although it does have its challenges. Being on-call around the clock makes a work–life balance difficult, and it can be hard for his wife Susan to find professional work. Once again showing a dry sense of humour, Wanguhu noted that rural GPs cannot hide if they make a mistake. ‘You see your successes and your failures down the street,’ he said. ‘The successes are really good – I’m not so sure about the failures!’ That last statement is purely hypothetical, of course.

When he finds time away from his work, Wanguhu and his family – Susan, son Kijana and daughter Lerrato-Mae – make the most of Waikerie’s Riverland setting, enjoying waterskiing and other water-based activities. As Kijana approaches high school age, there is a ‘very big conversation in the Wanguhu family’ about what lies ahead, but for the moment they have no plans to relocate. The people of Waikerie surely hope it stays that way.
Solving the tyranny of distance through telehealth

The Medicare Local in Mildura is helping GPs deliver star quality healthcare to its region through teleconferencing.

The Mildura region has been through tough times over the past decade. You don’t have to go far before you hear about a fruit grower who lost it all in the drought, or about the difficulties suffered by many in the local community. But you also hear of their perseverance, support and mateship in the face of unrelenting hardship during the 10-year dry spell.

The success of the Lower Murray Medicare Local (LMML) in Mildura is an affirmation of that spirit. It covers a vast region from Wentworth in NSW to Murrayville on the South Australian border and the towns of Sea Lake, Ouyen, Manangatang, Robinvale, Balranald, Mildura and all the spaces in between. And it is this far-flung community that makes up the client base of the LMML, but which is also an integral part of it.

Evolving from a Division of General practice into the LMML after it won the government tender, the ML operates out of the same building as the Mildura Private Hospital. It offers a range of services from mental health to allied health, care coordination for Aboriginal and Torres Strait Islander peoples diagnosed with chronic disease and e-health. Staff include an Indigenous outreach worker, health project officer and health promotion officer; a movement disorder nurse; a regional care coordinator for autism and developmental disorders as well as several e-health officers.

Telehealth is pivotal in the success of the LMML, and teleconferencing is a vital component of that healthcare delivery. Troy Bailey, the e-health and CPD manager, is responsible for connecting patients with their GPs and specialists, despite the geographical distance that separates them. Other regions, he said, may have all the specialist services in their centre and patients travel into that town to use them. ‘But Mildura is our centre and we don’t have anything ... we have very little specialist services ... we all travel all the time.’

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Photos

This page (left to right): Troy Bailey sets up a web-cam; the Lower Murray Medicare Local in Mildura; Bailey sits in the state-of-the-art consulting room in the Medicare Local in Mildura.
p 14 Bailey in his office demonstrating how web-based teleconferencing is set up.
Patients, through necessity, travel to Adelaide and Melbourne to see medical specialists, Bailey said, and ‘the public transport doesn’t exist’. The long-running train, the Vinelander, which ran between Mildura and Melbourne, was discontinued some years ago and ‘there’s nothing to Adelaide at all,’ Bailey added. For patients visiting specialists in Melbourne, ‘if you’re elderly, or you’re on your own, or you don’t have a carer, you get up at 3 am in the morning and go to the bus station in Mildura’. The bus goes to Swan Hill where the patient must disembark with all their luggage and board a train to Spencer Street Station in Melbourne via Bendigo. Once in Melbourne, the patient has to find their way to the consulting rooms of their medical specialist, and after their consultation stay overnight in the city before undertaking the arduous journey back home. Many elderly patients, Bailey said, estimate it takes about 2 weeks to recover from such a trip.

For families with autistic children, it can feel like an almost insurmountable task to get their child to a psychologist in Melbourne. ‘We have an autism officer here and we’re now helping that specific demographic,’ Bailey said. According to the parents it was costing them up to $3000 per trip to take their child to Melbourne. The travel costs, accommodation needs, taxis, eating out, the cost of caring for children left at home and taking time off work are extensive, Bailey explained. In response to the need, the LMML set up a telehealth procedure for autistic children in their consultation room that substantially reduces the stress and cost for families.

Although psychologist consultations are not covered by telehealth item numbers, Bailey said he had seen psychologists who were happy to charge less than a face-to-face consultation when doing a telehealth consult. ‘The patients, you can just see it in their face’, he said, ‘they are just so happy.’

Due to the ingenuity of the LMML, every computerised practice in Mildura is now set up for teleconferencing. Bailey and his colleagues at the ML have worked with the local doctors to install a web-based service that means all GPs need to conduct a consultation is a webcam and an internet connection. ‘They log into the service; it’s a team arrangement,’ Bailey said.

‘The patients, you can just see it in their face, they are just so happy.’

‘The GP’s workflow doesn’t change. They see their first 15 patients, and then the next one is a video consult so their patient comes in, they log into the service and the patient sits with their GP as they talk to the specialist.’ The process works a bit like Skype, Bailey said, where both the GP and the specialist log in and select who they want to speak to from a menu on the screen.

Bailey noted that many GPs find the process especially valuable because they are participating in the consult with their patient. In addition, they are having clinical discussions with the specialist about their patient and hearing the outcome firsthand.

More than 60% of general practices in the region are solo practices. Bailey offers them a personal service where he goes to their practices and sets up their teleconferencing system. ‘I give them advice and even provide them with some equipment. If they’re hesitant about buying a webcam, we’ll give them a webcam,’ he added. Bailey also attends the practice on the first occasion the GP conducts a teleconference. ‘I stand outside the room, so if there’s an issue they can call me in,’ he explained. He also runs a test prior to the first telehealth session. ‘I log-in and speak to the doctor from here,’ he explained, in order to check technical issues such as the sound and picture quality.

With only 22 local specialists and 66 visiting specialists, the delivery of healthcare in the LMML region is challenging. The visiting specialists are often only able to make it to Mildura every 3 months to see their patients, hence their waiting lists were beginning to parallel the winding Murray River. But since the ML’s teleconferencing support initiative, the situation has improved dramatically. A visiting rheumatologist, for example, has been able to reduce his waiting list from 6 months to 2 months due to assistance from Bailey and his team at the ML.

As well as bringing all the GPs on board via webcams in their surgeries, the LMML has invested in a teleconferencing room of its own for use by visiting specialists. This means a patient, instead of travelling to Melbourne or Adelaide, can come to the ML between face-to-face consults and see their specialist via video. The patient must be accompanied by a support person and this does not necessarily need to be their GP. In these instances it is often a nurse or staff member from the specialist’s Mildura clinic.

The LMML teleconferencing room is equipped with about $25 000 worth of infrastructure and the patient feedback about consultations has been tremendous. But it’s not just the patients who are happy with the initiative. The GPs and specialists are also impressed, and they’re making the most of the opportunity to provide care to their patients and simultaneously reduce their waiting lists.

With Bailey’s foresight and skill, many GPs and specialists in the Mildura region are reaping the rewards of teleconferencing. And for Bailey, every time he eliminates the need for one patient to make the difficult trip to the city, he feels he has done his job well.
Championing telehealth

For Merbein GP Dr John Buckley, teleconferencing ticks most of the boxes. As a solo GP in the small town on the Murray River 20 kilometres from Mildura, Buckley is in a position to know what will help deliver better care to his rural patients.

Working out of a small clinic in the main street of Merbein, Buckley’s patients usually travel a few kilometres to see him from the surrounding fruit-growing district. Troy Bailey, the manager at the Lower Murray Medicare Local (LMML), also travels out from Mildura to visit the Merbein practice and his technical assistance, according to Buckley, has been invaluable. Bailey set up his teleconferencing facilities and is always on hand to provide technical support and expertise.

‘The backup is really important,’ Buckley said, adding that government support is vital in delivering telehealth to rural patients. ‘Credit to the Medicare Local for doing a great job,’ he said, adding that the system is ‘All in all – rather seamless and effective. I don’t know if it solves all problems but there is a place for it.’

Buckley has become adept at using teleconferencing technology to help his patients receive specialist care. He described a patient who benefited greatly from a telehealth consult. Luckily, he said, it was with a specialist who was literate at teleconferencing and who helped ‘expedite things and make sure they worked well’. Buckley found he was able to organise a consult with the surgeon promptly, which saved a 3–4 month wait for a face-to-face appointment.

Teleconferencing ‘makes it easier for the patients’, he said. They’re ‘familiar with the clinic and you’re introducing them to somebody that you trust.’ The consultation required that Buckley examine the patient, hold his fingers up in front of the camera and ‘be the eyes and ears of the consultant’. He said he enjoyed being the ‘translator between the different disciplines’ where he was able to explain to the patient what the specialist was saying.

The three-way consult was useful for him too, as he was able to hear what his patient was being advised and he discussed care with the specialist himself. ‘I think there was better engagement’, he said. ‘He gave us some pointers and it was useful.’

Buckley said teleconferencing was especially useful for psychological discussions, and he described the tool as ‘an additional benefit’ to his practice, ‘rather than a transformative one.’ The relationship between his small practice and the LMML is obviously one that enables him to deliver superior care to his patients, and one that demonstrates what can be done with technology in rural and remote spaces.

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When Dr Jenny Wray of Narooma won the RACGP’s 2011 GP of the Year award, it was in recognition of her amazing commitment and generosity.

When I was about 7, I developed pneumonia, and in those days my parents just took me to town and I was left at the hospital,’ Wray said. ‘Over that period I just got to love the hospital. I loved the nurses, I loved the smell of the place … I loved the sound of all the drama. From then on I just decided that was going to be the life for me.’

As a student at a tiny rural school with only 16 students, the dream of making it as a doctor appeared distant, but as Wray grew older she realised her small-town upbringing wasn’t the obstacle it first appeared.

‘When I went to high school I realised I could actually keep up with my peers, and then I just started thinking maybe I could be a doctor,’ she said. ‘I never wanted to do anything else.’

Her persistence has paid off in spades. Now based in picturesque Narooma, a country town on the southern coast of NSW, Wray has turned her once-solo Lighthouse Surgery into a shining star. Almost unrecognisable from its humble beginnings in 1994, Lighthouse now has four permanent GPs, as well as a host of registrars, medical students, nurses and visiting allied health professionals. Wray attributes her practice’s growth to its policy of encouraging and training young doctors, and also being flexible enough to suit their needs.

‘I decided the only way I was going to get people to come and join me in the practice was to bring in lots of young people,’ she said. ‘We’ve had a lot of people coming and going, and something that has worked for me is actually accepting that. If people want to come and work for a day and a half, or they want to come and work for a couple of years, it’s actually okay.’

‘I say that to them: “don’t think you’re being given menial tasks. What you do is actually really helpful for us.”’

As well as being grateful for the help they provide, Wray said she derives great joy from seeing young doctors develop.

‘We love having those young people at the practice because although they aren’t necessarily committed to general practice … it gives them a wonderful perspective of what general practice is all about,’ she said. ‘If they’re going on to specialise, they have a much better appreciation of how it all works in general practice.’

‘It’s a scholarship and mentorship which has bought us a lot of joy and kept us in touch with kids from within the community.’

A simple but important factor in Lighthouse’s success has been its willingness to embrace the internet. When Wray first implemented her registrar program in 2005, she decided it was important to ‘put up a good show’ by creating a website for the practice. Not satisfied with the standard of the site she and her staff were able to design in-house, she bit the bullet and enlisted the services of a professional photographer and a graphic designer. The result was a detailed and user-friendly website that has helped build Lighthouse’s profile significantly. Wray’s patients have been impressed by the site; one of them told her that it ‘does almost everything except print prescriptions’.

Meeting community need is at the crux of rural general practice, so when Wray...
saw a service shortage in the nearby town of Bermagui, she worked to fix it. In 2011, Lighthouse’s sister clinic was opened in Bermagui, and the local community has since welcomed it with open arms. Lighthouse staff take it in turns to make the half-hour drive, with at least one GP or registrar staffing the smaller clinic every weekday.

Wray’s longstanding commitment to medicine and the continued evolution of the Lighthouse Surgery has been widely recognised. In 2011, she received the RACGP’s GP of the Year Award and Lighthouse was named General Practice of the Year by the College’s NSW Faculty.

She said she was taken aback by the recognition, so much so that she donated her $5000 prize – which she had planned to use on a development exam – back to the RACGP Foundation. ‘I was so honoured,’ she said. ‘I felt that if the College had actually made these awards, I just wanted to embrace it, make the most of it and give something back.’

This generous gesture was no one-off act. In 2001, Wray’s niece Helen was enrolled at Flinders University and wanted to make the most of her time as a student, so Wray and her husband Jock Munro offered to finance her accommodation in a residential hall. The money they provided over 2 years enabled Helen to have the time of her life; she made the South Australian junior cycling team, got involved in countless university activities and even met her future husband. When the experience was over, Helen’s only request was that other young people be offered the same chances she was. And so the Lighthouse Scholarship Fund was born.

Every year since 2005, Jenny and her husband have offered scholarships to students graduating from Narooma high school, supporting them for the duration of their university courses. This year they will provide scholarships to six students – bringing the total to 18 – including their first Indigenous recipient.

‘It’s a scholarship and mentorship which has brought us a lot of joy and kept us in touch with kids from within the community,’ she said.

‘So why does Wray give so much back to her community? It’s actually pretty simple: ‘I really know what makes me happy.’
Bruno rides for Catherine

A Perth couple’s ambitious adventure has so far raised almost $40 000 for Catherine Hamlin’s work in Ethiopia.

Just before GP registrar Dr Gracie Vivian and her partner, nurse Bruno Cordier, left for Ethiopia in March last year, they found a copy of Catherine’s gift in a second-hand book store. The pair had been only vaguely aware of Dr Catherine Hamlin’s work treating fistulas in the African country, but after reading her story they were so impressed they felt compelled to take a deeper look. When they visited one of the small rural hospitals established by Hamlin in Ethiopia, the true importance of her work hit home.

‘The women just looked very vulnerable, but you could see that they knew they were well cared for and protected there,’ Vivian said. ‘Some of their stories were quite humbling to hear, the sort of tragedies they’d been through.’

At dinner that night the two met a group of men who were cycling from London to Cape Town. The serendipitous encounter sparked an idea as to how they could contribute to Hamlin’s cause.

‘Bruno and I got talking, and I said to him “Why don’t you do a bike ride of that sort of calibre for the Hamlin Foundation?”’, Vivian said. And so they decided that Cordier would ride from Sydney to Perth – unassisted – during the height of the Australian summer.

The courageous Frenchman-come-Aussie set off on 11 January 2013 and arrived in Perth on Valentine’s Day, just in time for a big welcome-home kiss.

It was an arduous journey of more than 4000 kilometres, but regular contact via Skype kept both partners in touch, and some unexpected help along the road put a smile on Cordier’s face. ‘He met a lot of very generous people who shouted him meals for free and gave him campsites for free and doused him in icy cold water when they saw him on the road,’ Vivian said. ‘He was quite moved by all the people he met along the way.’

As much as Cordier enjoys cycling around Perth, he had never undertaken anything like his recent adventure. ‘He’s well used to commuting by bicycle within the metropolitan area … but he’s never done anything like that before, so he really did have to train a lot,’ Vivian said. She added that, while it would have been nice to support her partner on the ride, her ‘skill set doesn’t lie in cycling across massive continents’.

The generosity of Australians – those known to her and also strangers – has been touching for Vivian. ‘It’s not the easiest time financially … but there has been quite an outpouring of support and an interest in the cause itself,’ she said. ‘Help has come from places we would not expect at all.’

‘People have been amazingly generous. We’ve had people organise their own little fundraisers at work.’

It’s this kind of selflessness that has seen the ride’s initial fundraising target of $20 000 smashed. Donations can be made until the end of March, and with a bit more help the $50 000 mark is not out of reach. Visit hamlin.org.au.

Visit the Hamlin Fistula Foundation at hamlin.org.au
Tea and coffee

Healthy tips for tea and coffee consumption

- Instant coffee is brewed coffee with the water removed, hence it has the same nutritional benefits as ground or roasted coffee.
- If drinking coffee, consume less than five cups per day of paper-filtered, percolated, café style or instant coffee in preference to boiled or plunger coffee.
- If you are watching your weight, use intense sweeteners, and low fat or skim milk. Use of intense sweeteners instead of sugar saves 16 calories or 68 kilojoules per teaspoon. If adding milk, use reduced, low fat or no fat milk.
- If you are pregnant, ensure your caffeine intake is less than 300 mg per day; decaffeinated drinks are a healthier choice. Be aware of other sources of caffeine such as energy drinks.
- Consider caffeine metabolism genetic testing to find out your personalised daily-suggested caffeine intake.
- Include a moderate intake of tea and coffee as part of a healthy balanced eating plan.

<table>
<thead>
<tr>
<th>Drink</th>
<th>Caffeine content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instant coffee</td>
<td>60–80 mg/250 mL</td>
</tr>
<tr>
<td>(1 teaspoon)</td>
<td></td>
</tr>
<tr>
<td>Percolated coffee</td>
<td>60–120 mg/250 mL</td>
</tr>
<tr>
<td>Tea</td>
<td>10–50 mg/250 mL</td>
</tr>
<tr>
<td>Energy drinks</td>
<td>80 mg/250 mL</td>
</tr>
<tr>
<td>Coca cola</td>
<td>48.75 mg/375 mL</td>
</tr>
</tbody>
</table>

Source: Food Standards Australia New Zealand

Having a cup of tea or coffee is one of Australians’ favourite pastimes, but are these hot beverages good or bad for your health? There are many common misconceptions about these drinks that can cause confusion about whether to recommend them to your patients. While there are no recommended daily intakes for tea and coffee, recent research suggests that moderate daily consumption is safe and may actually provide some health benefits. Moderate consumption equates to approximately 300 mg of caffeine (about 3–4 cups of regular coffee or 6–8 cups of tea). However, it is important to note that caffeine levels of different types of coffee and tea vary substantially. See the table on the left for more information.

Dehydration

The most common misconception about tea and coffee is that they have a dehydrating effect. Caffeine, especially in doses above 300 mg in one serving, may have a mild, temporary diuretic effect. However, this effect decreases with habitual intake. Tea and coffee, being predominantly water, are an important source of fluid and help to meet daily fluid requirements.

Cardiovascular health

Tea and coffee may offer some cardioprotective effects. Moderate coffee consumption has been associated with a decreased risk of stroke in women, in particular those who are former smokers and non-smokers. The National Heart Foundation recommends that adults include black or green tea in their diet as an excellent source of antioxidants (polyphenols), which are important for cardiovascular health. Green tea consumption has also been associated with reducing LDL or bad cholesterol. The effect of coffee on cholesterol levels is determined by its method of preparation. The National Heart Foundation recommends consuming only paper-filtered, percolated, espresso or instant coffee. Coffee consumption (fewer than five cups per day) has a relatively small effect on increasing blood pressure; however, coffee is not generally considered as a risk factor for hypertension.

Cancer

Research evidence suggests that it is unlikely coffee or tea are associated with an increased risk of cancer. But there is insufficient or conflicting information on whether coffee or tea may have a protective effect against certain cancer types, and more studies are needed.

Type 2 diabetes

Studies indicate that regular moderate consumption of coffee is associated with a decreased risk of developing type 2 diabetes. A meta-analysis by Australian researchers found there was a 7% decreased risk of developing type 2 diabetes with each additional cup of coffee consumed daily. Similar findings were seen with decaffeinated coffee and tea.

Pregnancy

Some studies suggest that high caffeine intake during pregnancy may increase the risk of miscarriage or having a baby with low birth weight.

Caffeine metabolism

A lesser-known fact about caffeine is that it is metabolised at different rates depending on a person’s genes, and therefore can affect people in different ways. This is why some people have one cup of coffee and can’t sleep all night, but others can have multiple cups and fall quickly into a deep sleep. The CYP1A2 enzyme metabolises 95% of caffeine in the liver, which is regulated by the CYP1A2 gene. It can be important to know if you are a slow caffeine metaboliser as you are at an increased risk of having a heart attack. Genetic tests are available to determine if you are a slow or fast caffeine metaboliser.
In a new book to be published by Pan Macmillan in April, Rebecca Sullivan bakes Whoopie pies – a cross between cake and biscuit, and a huge trend when she lived in London.
Carrot & orange whoopie pies

Ingredients
250 g (1 ¾ cups) plain flour
1 teaspoon bicarbonate soda
½ teaspoon baking powder
¼ teaspoon grated nutmeg
¼ teaspoon ground cinnamon
¼ teaspoon ground ginger
¼ teaspoon salt
125 g butter
100 g caster sugar
100 g (½ cup lightly packed) brown sugar
2 eggs
1 teaspoon vanilla extract
2 carrots, grated
zest of 2 oranges

Filling
250 g cream cheese, softened
150 g mascarpone
120 g (1 cup) icing sugar, sifted
zest and juice of half a lemon

Method
1. Sift the flour, bicarbonate of soda, baking powder, cinnamon, ginger and salt into a large bowl.
2. In another bowl, cream the butter and sugars with an electric mixer until light and fluffy. Add the egg and vanilla and mix until combined.
3. Add the carrot and orange zest to the creamed mixture and mix well. Fold in the dry ingredients. Refrigerate the mixture for about 30 minutes.
4. Preheat oven to 180°C. Line two baking trays with baking paper.
5. Using a large spoon, place 16 neat scoops of the mixture about 5 cm apart onto the trays. Bake one tray at a time in the middle of the oven for 10–14 minutes, or until the cakes retain a slight dent when touched. Let them cool on the trays for a few minutes, as they will be quite soft, then transfer to a wire rack to cool completely.
6. For the filling, beat the cream cheese in a small bowl until smooth, then beat in the mascarpone until smooth. Add the icing sugar, juice and zest. Mix until combined. Use the filling to sandwich the whoopies together.

Makes 8
A lifestyle-modification program for adult survivors of blood cancer could be applied as a model for a much broader population.

Dr Sharon Avery is the haematologist who established and continues to run the clinic. She said the increasing number of blood cancer survivors created a need for ongoing care programs that cater exclusively to adults.

‘It has certainly been an area of interest for quite a long time in paediatric populations, but I think in adult cancer survivors the interest is really only perhaps in the last few years,’ Avery said.

The more she worked with the survivors, the clearer it became that many of their health problems were caused or exacerbated by an unhealthy lifestyle. Her response was to develop the Positive Change for Life program, which uses a combination of strategies to help survivors improve their lifestyle and

The Alfred Hospital’s Late Effects Clinic in Melbourne was opened in May of 2008 to provide ongoing care to blood cancer patients who have undergone stem cell transplants. Improvements in the relatively new procedure have led to a greater survival rate and better long-term prognosis, but many patients continue to suffer ‘late effects’ – health problems that arise or persist years after treatment. The clinic supports adult patients who are a minimum of 2 years into their recovery from a stem cell transplant. Assessment has shown that 60% of those patients are overweight or obese, half are hypertensive and many still suffer from the psychological effects of their battle.

Photos
Left to right: Dr Sharon Avery; Dr Michael Sargeant.
prevent late effects. It has received funding for 2 years from the Victorian Government’s Department of Health and commenced in June 2012.

Positive Change for Life can accommodate up to 50 patients per cycle, each taking part in the program for a year. Participants receive assistance from all angles, including tailored nutritional advice from a dietitian, personalised and group exercise sessions, ongoing support from the Late Effects Clinic and monitoring from their regular GP.

Avery said it was clear that lifestyle intervention was required in cancer survivors more so than in the broader population. ‘All of these health issues are very common in the general population,’ she said. ‘What we’ve found, though, is … the prevalence of these conditions is much higher than you would expect in a population of people who hadn’t had a cancer diagnosis.

‘Those people will have some defined illnesses that they bring with them. However, for the majority of people this is cancer treatment-related and any existing problems are likely to be exacerbated.’

Dr Michael Sargeant is the GP representative for the Positive Change for Life program. He said the mental effort required to survive cancer treatment often left patients unmotivated to live healthily in the years after, and that the program’s aim was to help them change that mentality.

‘People like this sometimes think “I’ve dodged a bullet, so I’m going to live my life the way I really want to,” and throw caution to the wind,’ Sargeant said. Avery nominated the group exercise sessions as perhaps the most effective, as patients build rapport with others facing similar difficulties. Sargeant added that motivation is an area where the ongoing input of GPs could be extremely helpful for patients. He described the program as a ‘multi-disciplinary approach’, in which GPs play the role of ‘conductor’.

‘It’s innovative because it’s a real attempt to include a whole range of resources out in the community, to introduce patients to those resources and to have them integrated into what basically is the medical management of the patient,’ Sargeant said. He added that GPs have ‘gone from being very much the primary treater to very much the primary overseer’ for many patients with ongoing needs.

Avery and Sargeant both acknowledged that the number of patients who require stem cell transplants is small, so most GPs would probably never have any direct involvement with this particular program. However, they said the model of using available community resources to manage patient health preventively was one that could be applied to a range of other areas.

‘The principles are easily transferrable to other groups of patients,’ Avery said. Sargeant added that ‘if we can get that message through to GPs, we’re much more likely to get them on board for this particular project’.

Although the first cycle of the program is not yet complete, the measurable results have been encouraging and the patients’ change in attitude even more so. Many are well on their way to achieving their aims and feel a sense of emotional wellbeing that might have been missing previously. ‘I think the message people are sending back is that they’re responding because “somebody’s really interested in me”,’ Sargeant said.

The program offers a range of incentives to keep patients motivated. Avery nominated the group exercise sessions as perhaps the most effective, as patients build rapport with others facing similar difficulties. Sargeant added that motivation is an area where the ongoing input of GPs could be extremely helpful for patients. He described the program as a ‘multi-disciplinary approach’, in which GPs play the role of ‘conductor’.

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The program is ‘as open-door as we can possibly be’, Avery said, but nominated interest from GPs as one area with room for improvement. Referrals can be made online, in person, in writing or over the phone. GPs with eligible patients are encouraged to contact the Late Effects Clinic.
Global postcards

Travelling? Here’s a collection of ideas to enhance your trip.

Airbnb

For those who enjoy a bit of luxury, Airbnb is a balance between culture and comfort. The concept is simple; hosts display their house on the website as if it were a bed and breakfast and charge what they believe is a reasonable nightly rate – usually much cheaper than an equivalent hotel room. Guests can search by location and filter their results using parameters such as price, type of accommodation and amenities. After their visit, they are encouraged to leave a review to let others know how their experience was. For the sake of comfort and safety, it’s worth choosing accommodation that has received positive feedback.

Part of Airbnb’s charm is the range of options available. Travellers can stay in anything from a ‘run down old house in Brunswick’ ($15/night) to a ‘rainforest tree house’ in Costa Rica ($81/night) to President Obama’s five-star winter retreat in Hawaii ($3790/night).

Bookings and payments are made securely through the Airbnb website, but the intimate nature of the system means guests can choose whether they want to interact with their hosts or keep to themselves. With such a choice of unique experiences available, Airbnb is bound to gain more prominence.

Flight comfort

Once you’re in the sky and the cabin is pressurised it can become quite chilly, so it’s a good idea to take a cardigan or light blanket with you. If you’re flying overnight, a body-sized blanket can be nice to snuggle under. For those who take their online comfort seriously, consider a silk blanket available from Magellan’s online travel store at www.magellans.com.

Flight pillows are also a good investment and it’s important to shop around and purchase the one that suits your sleeping style. Horse-shoe-shaped pillows containing small beads of foam are very popular because they are light and can be moulded to suit individual needs. The Komfort Kollar selected by The Wall Street Journal as the best overall and best value travel pillow is also a popular choice, and is available in foam or inflatable from Magellan’s or komfortkollar.com.

For those with sinus problems or sensitive ears, good quality earplugs, such as Earplanes, which equalise the pressure either side of the eardrum when flying, are indispensable.
Hidden gem: Theth, Albania

Villages in Europe don’t come more isolated than Theth. Located 4 hours from anywhere in Albania’s north, the tiny collection of houses ringed by a spectacular mountain range has let time pass by over the past few centuries. Forget phone reception or internet access – barring the occasional light bulb, life in Theth is essentially the same as it was 100 years ago. Spend a day with locals and witness every stage of the food production process, or take a walk along the river to experience nature at its most serene.

Getting there is half the fun. Theth is accessible only by ex-communist minibus along an extremely bumpy road, but the characters you’ll meet on the way make it a memorable trip. When you reach Theth, you’ll probably be greeted by a 12-year-old boy named Francesco. It’s best to follow him to his family’s guesthouse; he’s the only person in the village who speaks English …

Expect to pay €20 per night for guesthouse accommodation and three meals. Remember that the locals live hand-to-mouth, so a small tip doesn’t go astray.

Appy holidays: Triplt

Ever struggled to keep track of your itinerary while on holiday? Now there’s an app that can keep all your best laid plans neatly organised in your pocket, without the need for printing paper records or trawling through your email inbox. It’s called Triplt, it’s free, and it’s making life easier for tech-savvy travellers.

All users need to do is forward their confirmation emails for flights, tours and accommodation to Triplt, then the app takes care of the rest. It organises information into easy-to-manage itineraries – a separate one for each destination – allowing users to view and edit their plans at the touch of a screen. Some of the handiest features of Triplt include the maps, directions and daily weather forecasts provided for each destination. The functionality of this app has earned it a user rating of 4.4/5 on Google Play from more than 20,000 votes.

For $49 a year, users can upgrade to Triplt Pro, which includes extra features such as flight delay notification, alternative options if a flight gets cancelled and 1-year memberships to Hertz #1 Club Gold and Regus Gold.
First do no harm: being a resilient doctor in the 21st century

Professor Michael Kidd and Associate Adjunct Professor Leanne Rowe wrote this inspiring little book in 2009, but its wisdom is ageless. The authors take the Hippocratic Oath and expand it to include the health and wellbeing of medical practitioners, as well as the patients they treat.

‘To remain resilient and to care for others, we must also care for ourselves,’ they write, and so sets the tone for the rest of the book. In a frank discussion on physical and psychological health there is a poignant reminder that doctors also need to be patients occasionally in order to remain healthy. They need to overcome the unrealistic expectations of others and be true to themselves both as human beings and as doctors. And this valuable book doesn’t just raise awareness, it suggests solutions. There are thoughtful checklists and ideas, and there are provocative questions and gentle reminders.

The authors propose eight principles that make a resilient doctor, and, indeed, a healthy, fulfilled individual. They are: make home a sanctuary, value strong relationships, have an annual preventive health assessment, control stress not people, recognise conflict as an opportunity, manage bullying and violence assertively, make our medical organisations work for us and create a legacy.

Sounds like a perfect recipe? Probably, but there’s more. There are highlighted sections throughout the book that contain tips for everyday problems and personal dilemmas. There are tips for responding to personal criticism and tips for giving criticism; tips for dealing with conflict more effectively and tips for negotiating conflict. The list of tips for de-escalating aggressive behaviour demonstrate the emotional intelligence implicit in the authors’ writing. ‘Appear calm, respectful, self-controlled and confident, use reflective questioning ... use a neutral tone and offer to help ... use neutral body language’ and ‘embrace silence.’

This book is a gem and a must-read for every medical student and GP who’d like to be reminded of the privilege of practising medicine.

Free book give-away

First do no harm: being a resilient doctor in the 21st century by Leanne Rowe and Michael Kidd.

This popular book written by two visionary GPs should be in every doctor’s bookcase. It provides medical practitioners with information and resources on strategies for self-care. It also discusses the importance of doctors building supportive relationships with their own doctors, families, friends, colleagues, patients, the physical environment and with medical organisations.

If you’d like to go in the draw to win one of 20 copies of this book, email your name and address to goodpractice@racgp.org.au.

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