



EDITION 141

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Executive report	2
Primary health care reform— COAG decision awaited	3
‘Closing the Gap’ in Indigenous Health	3
HNEAH Communicable Diseases Bulletin	4
Hep C Pre-test counselling – What is the big deal?	4
Go mental for new health resources	5
Menopause— perception vs reality	6
Prostate Cancer— to test or not to test, that is the question	7



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# The Link

Improving Health in the New England through General Practice

## Palliative Care in Cambodia

Michael Barbato recently presented an education session on palliative care at the Division in Armidale. During this visit he asked that his fee be donated to a palliative care service he has become involved with in Cambodia. Michael Barbato has received an OAM for his contributions to palliative care in Australia and has just published his second book on palliative care, “Reflections of a setting sun”.

**Maryknoll** is a registered non-government organisation (NGO) and has been operating in Cambodia since 1989. It is run by Father Jim Noonan who, with the help of local health workers, provides health, housing and educational services to more than 500 adults and 300 children, most of whom have, or are affected by AIDS. Many of the children are orphans having lost both parents to illness (usually AIDS).



**Cambodia** is a country of 11 million people and has only recently emerged from the shadows of political turmoil and mass killings. It is one of the poorest nations in SE Asia, with mass unemployment, low wages (<\$300 US/annum) and a high mortality rate due mainly to infectious diseases including HIV/AIDS and TB. Infant mortality is one of the highest in the world and few adults survive beyond 50 years of age. AIDS is particularly rampant in Cambodia and the situation there is similar, although not quite as bad as Africa.

**The care of the sick and dying** is compounded by an overwhelmed health service, lack of money, inadequate numbers of trained doctors, nurses

etc and the absence of affordable medicines. Treatments that are freely available in Western countries such as Australia are either unavailable or beyond the financial reach of most Cambodians. Many children and adults die not because their disease is incurable but because they cannot access the necessary care and treatment. For those who are dying there is virtually none of the care and treatment (such as pain relief) that we in Australia take for granted.

**Donations** to Maryknoll Cambodia go toward healthcare, food and rent for the homeless and the sick and to provide humane care for the dying. A small proportion helps finance education and AIDS awareness programs that form a vital part of the country’s prevention strategy. All Maryknoll’s running expenses come from approved budgets NOT donations.

**How far does the money go?** The average cost of dinner for two in an Australian restaurant would house, feed and medicate a Cambodian family for several months and pay for the educational needs of the children.



# The Link

Improving Health in the New England Through General Practice

## Executive Report

### Tanya Norman, Acting CEO

*“To develop this facility to meet the needs of the students clinical and GP training requirements and to the increase the capacity of general practice to provide training places”*

The future of clinical training and general practice placements for medical students in the Northern Tablelands was given a significant boost following the recent announcement that the University of New England received \$5.5 million from the Commonwealth Government to build a Clinical School in Armidale to support the Joint Medical Program (JMP).

NEDGP has been in consultation with UNE to develop this facility to meet the needs of the students' clinical and GP training requirements and to the increase the capacity of general practice to provide training places.

The annual GP Survey undertaken by NEDGP will be available in three different formats this year. I will be in contact with you shortly to offer one of three options: a face-to-face meeting, a paper-based document or an online option.

We are working with North West Slopes and Barwon DGP to develop the online survey in response to a growing number of requests for electronic-based feedback tools.

Unfortunately, attempts to recruit a GP Locum have been unsuccessful to date. The second round of advertising is underway.

This time other media outlets will be targeted (eg Australian Doctor) with the hope of attracting a suitable candidate.

Division staffing levels are approaching capacity in many of our regional offices. Glen Innes is really feeling the pinch with the expansion of the Aboriginal Health Services Program and larger premises are being investigated. NEDGP will soon have an official presence in Tingha. Tom Jerrard (AHW) will continue to provide a part-time service in Inverell and from the 12th April he will have an office at the Tingha MPS to increase support to this community.

This week we farewelled Priscilla Chalmers, Mental Health Project Officer. Priscilla will be missed and we wish her well in her future endeavours. This position will be advertised shortly, along with a new Executive Assistant – Aboriginal Health Services position. This will take the total number of employed staff to more than fifty.

For those of you who haven't caught up with the news, Sally (Armitage) had a baby boy on 25<sup>th</sup> February and both are well.

We hope you like 'The Link' in its' new format.

*Tanya Norman*

## Opportunity to pilot CDSM on-line training - FREE

Ever had a patient who wanted **you** to fix all their health problems? Ever wanted a magic wand to better engage patients in chronic disease self management (CDSM)?

This may not be a magic wand, but Hunter New England Health, together with the Heart Research Centre, has developed an on-line learning package for health care professionals working with people with chronic conditions.

Based on CBT and Motivational Interviewing principles, it equips clinicians with **tools** and **strategies** for effective communication and goal setting with patients. The five modules are expected to take a total of approximately 5-6 hours to complete, and are being offered FREE for the pilot period only (May 1-12, 2010) after which time it will be available from the Heart Research Centre at a cost of up to \$200 per person (discount available for groups).

CDSM is an effective tool for engaging patients in the GP Management Plan process, to ensure goals and tasks are patient orientated and achievable. For practice nurses assisting GPs in documenting GPMPs or utilizing the five Chronic Disease Management items (no. 10997), available to patients under a current GPMP or Team Care Arrangement, CDSM is valuable in supporting the patient through the change process and encouraging compliance to treatment.

Suitable for GPs, practice nurses, allied health and community/acute nurses.

Application is currently underway for CPD points and endorsement from RACGP.

Further information is available by calling Kay Cope (Practice Development Officer, HNE Health) on 0419 293075.

## Primary Health Care Reform– COAG decision awaited

Primary Health Care and General Practice could expand dramatically after the Rudd Government announced major reforms to Australia's health and hospital system last month.

The reforms, which Prime Minister Kevin Rudd said were the most significant since the introduction of Medicare almost 30 years ago, would see \$600 million invested in delivering 5,500 new GPs in training or practice by 2020. The reforms would also see the Federal Government take over 60 per cent of hospital funding, as well as becoming solely responsible for the funding and policy of GP and Primary Health Care Services. Mr Rudd said this meant there would be more integration between acute and primary health and take pressure off Australian hospitals, which have internationally high hospitalisation rates – currently double that of Canada.

“Because one level of government will be responsible for both the majority of hospital costs and all of primary care more

people will be treated outside of hospital – as they often should be,” he said.

Mr Rudd said pressure could be removed from hospitals by reducing the number of unnecessary hospital admissions – estimated at 441,000 admissions, or 9.3 percent of total hospital admissions, in 07-08 – by making GP services better co-ordinated and more tailored to suit patients' needs.

“Too many patients are receiving uncoordinated care because of the lack of integration between hospitals and out-of-hospital services,” he said. “We know that we cannot fix the imbalances in our system if we don't have a strong primary care system.”

Mr Rudd said the reforms would be put to the Council of Australian Governments (COAG) on April 11 and if they were not accepted, a referendum would be put to the people of Australia by the next federal election or in conjunction with it.

## NEDGP to ‘Close the Gap’ on Indigenous Health Outcomes in the New England



NEDGP is playing an active role in closing the gap in Indigenous health outcomes, with visible results throughout New England, as Australia celebrates the third anniversary of the initiative. Many Australians are not aware of the severity of the Aboriginal health crisis and the grim statistics which are comparable to those of third world countries.

Indigenous Australians have a life expectancy approximately 17 to 20 years less than non-Indigenous Australians. Chronic disease is responsible for two thirds of the life expectancy gap, with rates of diabetes 3.5 times higher among Aboriginal Australians and associated death 10 times more likely.

Heart disease and stroke affect Indigenous men at three times the rate of other Australian men, cervical cancer in Indigenous women is 5 times the rate seen in non-Indigenous women, and Aboriginal babies die at twice the rate of other babies. Deaths from kidney disease are up to 10 times more common. NEDGP Executive Officer for Aboriginal Health Natalie Green said the

Division had seen an increase in completed annual diabetes cycles of care and an improvement in HbA1c values in patients, as well as seeing more Aboriginal patients graduate from the Cardiac Rehabilitation program.

“It's important to remember though that improving the health outcomes of Aboriginal people is only one facet that exists in moving toward closing the gap. It also involves things such as education and employment equality and opportunity,” Ms Green said.

She said NEDGP's Aboriginal Health team consisted of 14 people, 10 of whom were Aboriginal, resulting in huge positive affirmation within the community.

“It allows for role models and also a community connectedness that supports what NEDGP is committed to achieving,” she said. Closing the Gap represents an agreement between the Council of Australian Governments (COAG) and states and territories to achieve equality in health and life expectancy for Indigenous people by 2030.

## Cultural Immersion Program for Health Professionals

An opportunity exists to visit Woodygupildiyerr (Woody), which is a six hour drive south-west of Darwin to learn about contemporary Aboriginal lifestyle in rural Australia. The program runs for 5 days and is open to health professionals, educators, trainers, and administrative staff who work in an Indigenous cross-cultural context.

This is a PDP accredited program which attracts 30 core points. To access the program information on RRMEO, go to [www.rrmeo.com.au](http://www.rrmeo.com.au). It is recommended that you enquire and register early to secure your place in this unique program. Hurry, there are only 7 places available in 2010. To register your interest, please contact Belle Allison of the Northern Territory General Practice Education by email [belle.allison@ntgpe.org](mailto:belle.allison@ntgpe.org) or phone 08 8946 6958.

## Hunter New England Area Health Communicable Diseases Bulletin

Hunter New England Area Health has presented the first electronic edition of the Communicable Diseases Bulletin, which was previously a four page hard copy. Here you will find a summary of the articles from the January-February edition, along with links to the complete articles, which can be found online.

### **Continue to actively encourage on-time pertussis vaccination** page 1

HNE had a 3 fold increase in pertussis notifications in 2009 compared with 2008 (1459 and 579 respectively). This has occurred across all age groups. Adults in contact with infants should continue to be actively encouraged to be immunised to lessen the impact of this outbreak and particularly to protect young infants. The link below discusses pertussis vaccine efficacy.

### **The National Privacy Principles (NPPs) and notifiable conditions** page 1

Recently concern has been expressed about sharing patient health information with HNEPH communicable diseases staff. GPs are able to disclose information with HNEPH staff under the auspice of the *Public Health Act 1991*, mandatory reporting of specified diseases.

### **Erratum: Post exposure treatment for Australian Bat lyssavirus** page 1

Need to include a dose of rabies vaccine at Day 7 post exposure to virus. Availability of both Tamworth and Newcastle offices of HNEPH communicable diseases staff clarified.

### **Meningococcal disease summary HNE 2005-2009** page 2

59 cases of meningococcal disease were notified to HNEAH for 2005 – 2009. The 0-4 year age group continues to be the most common age group affected. Serogroup B has been the most common serogroup notified. A dramatic decline in cases with serogroup C has occurred since the introduction of the Meningococcal C conjugate vaccines in 2003. Prompt testing, treatment and notification to HNEPH for contact management remains the essential steps for clinicians.

**Table of notifiable conditions** page 3- Table of totals of notifiable conditions in HNE up to 22 January 2010

[http://www.hnehealth.nsw.gov.au/data/assets/pdf\\_file/0010/69832/HNEPH Bulletin Jan-Feb .pdf](http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0010/69832/HNEPH_Bulletin_Jan-Feb.pdf)

### H1N1 Update: Chief Medical Officer Letter to GPs

On 24 March 2010, The Australian Government Chief Medical Officer wrote to Australian GPs with an update regarding the seasonal influenza vaccination. In addition, a new H1N1 Influenza Vaccination General Practice poster, brochure and fact sheet have been released. Detailed information and resources to support Australian General Practice in managing the pandemic, including the RACGP Pandemic Flu Kit, can be found at [www.racgp.org.au/h1n1](http://www.racgp.org.au/h1n1).

## What's the Big Deal about Pre-test Counselling?

Hepatitis C testing can be about much more than just taking blood. Pre-test counselling (also known as pre-test discussion) is a procedure for obtaining a person's informed consent for a non-routine medical procedure. Testing for Hep C should not be treated as standard or routine because the consequences of a positive result can be considerable for the individual. Pre-test counselling is not just about obtaining informed consent. This one-to-one discussion with a person prior to testing affords a valuable opportunity for education, health promotion, transmission prevention, as well as assessment and referral. Testing a client for Hep C without pre-test counselling may be depriving them of the health and psychosocial benefits that this procedure can offer. Hepatitis NSW provides a useful fact-sheet that describes the main elements of Hep C pre and post-test counselling. This can be obtained from their website or by phoning the Hepatitis Helpline: 1800 803 990.

In addition, ANCAHRD's National Hepatitis C Testing Policy (August, 2003) provides a comprehensive overview of the guiding principles of pre- and post-test counselling and includes important issues such as informed consent and confidentiality (pp 13-16).

Albion Street Centre Education provides a four-day course, twice a year, in 'Pre- and post- test counselling for HIV and Hep C'. For more information, call (02) 9332 9720.

*Katherine Coote is the Clinical Psychologist / Hep C Liaison Psychologist at the Albion Street Centre, Prince of Wales Hospital, Sydney*

# Go Mental for New Health Resources

*The recent years have seen a greater push from both the public and private sector for incentives to respond to the ever growing mental health crisis. In response to the increased prevalence of mental health disorders, there are a number of new initiatives to support GPs both in practice and in their own professional capacity to cope with the greater demands placed on them as practitioners and the demands on their own personal wellbeing.*

There are a number of resources currently available to GPs to use with patients and to address self care and management. In particular the Royal Australian College of General Practitioners (RACGP), has begun a nationwide program under the 'Healthy doctors initiative' to address the alarming statistics around GP health and emotional wellbeing.

<http://www.racgp.org.au/peersupport/network> - a part of the *beyondblue* and the RACGP Medical workforce Initiative aimed to improve health and wellbeing through the development of a peer support network and establishment of an e listing of medical practitioners willing to offer medical services to their peers and colleagues from other craft groups.

There are also a number of fantastic new resources available for GPs to refer patients to or to up skill in the area of mental health diagnosis and treatment , a number of these resources are accredited to the RACGP and ACRRM.

Follow the links below:

<http://www.GPcare.org> provides up-to-date information and resources for GPs to improve mental health access and outcomes for patients.

<http://www.cci.health.wa.gov.au/about/index.cfm> The Centre for Clinical Interventions (CCI) provides clinical service based on current evidence-supported practice and aims to best meet the needs of our clients. As CCI forms part of the

public mental health system, the service we offer is free.

<http://www.crufad.org> is a self help online clinic providing both resources for GPs working with patients with mental health problems as well as an

online virtual clinic that patients can do in their own time. The virtual clinic provides feedback to GPs on patient progress and outcomes from the online tool. This website also provides a range of research and patient management tools.

<http://www.sane.org> For GPs looking for ways to help patients deal with often confusing and distressing mental health problems, a new initiative from SANE

## Did you know

- 53% of Australian General Practitioners have considered leaving general practice because of work related stress
- 20% of Australian Anaesthetists have high rates of emotional exhaustion
- 12.8% of Australian metropolitan GPs had severe psychiatric disturbance, indicative of clinical depression, anxiety or other psychiatric conditions
- Male medical practitioners may be twice as likely to suicide as other professional males in general, while some research suggests that female medical practitioners are four to six times more likely to suicide than other professional women.

Australia is useful. SANE Talk is a range of free podcasts that help clarify mental illness and associated issues. Each podcast focuses on a particular mental health problem. Other topics are obsessive compulsive disorder, bipolar disorder, psychosis, schizophrenia, borderline personality disorder, eating disorders, and SANE steps: how to help when someone considers taking their own life.

## General Practitioner Anaesthetists' Locum Scheme (GPALS)



GPALS is a Locum Scheme especially for GP Anaesthetists throughout rural and remote Australia. Funded by the Australian Government, the Scheme is also the facilitator of Government subsidies for rural/remote GP Anaesthetist locum relief.

Host subsidies per GP Anaesthetist requiring relief include:

- \$750/day for locum service fees up to 14 days/financial year ( $\$750 \times 14 = \$10,500$ )
- and up to \$1500/placement for locum travel costs.

Rural practices/hospitals that arrange their GP Anaesthetist locum privately are also eligible to access the subsidies. Access is easy - there is no administration fee or hidden costs and the paperwork is effortless (3-5 minutes to complete). GPALS is also seeking GP Anaesthetists (JCCA accredited or equivalent) or Specialist Anaesthetists to register for locum work. A travel time subsidy of up to \$500/placement applies. For more information, please visit the Australian Society of Anaesthetists at [www.asa.org.au](http://www.asa.org.au), call Dianne on (02) 9327 4022 or send an email to [gpals@fed.asa.org.au](mailto:gpals@fed.asa.org.au).



# The Link

Improving Health in the New England Through General Practice

## Menopause – Perception vs Reality

Edited by Therese McGuren, NPS Program Manager

*Information abounds on 'hormone imbalance' and dealing with menopause 'naturally'. Many women are turning away from approved and regulated pharmaceutical postmenopausal HT and using hormonal lozenges or troches which are absorbed through the buccal mucosa. These are called 'bio-identical' or 'natural' hormones, however, these hormones are still manufactured in a pharmacy rather than a factory, but are usually the same or similar hormones as prescription HT. Pharmacists making the lozenges are not required to adhere to codes of conduct of the professional pharmaceutical body – Medicines Australia – therefore there is limited quality control or assurance process and no formal regulation. There is limited preclinical, and no significant clinical research into dosage, safety and efficacy. The hormone formulations made in a pharmacy are often very expensive.*

As new evidence has emerged over the last decade there has been debate about the safest and most effective treatment options for managing the symptoms of menopause.

The National Prescribing Service (NPS) says the decision about which treatments to use should be made jointly between the health professional and the patient.

Concerns about the potential adverse affects associated with hormone replacement therapy have led to an increased interest in non-hormonal therapies. While many women often think complementary medicines are safer, the evidence is still inconclusive and there have been reports of adverse effects and interactions between complementary medicines with conventional medicines.

One recent development has been the increasing use of 'bio-identical hormone therapy' and GPs may have requests for information or be asked to prescribe this treatment. They are formulations (usually a troche, which dissolves in the mouth) of one or more hormones which claim to be tailored to a woman's individual hormone needs, often following a saliva test for current hormone levels. One of the claims made is that the hormones used are identical to those used in the human body, rather than synthetically produced.

Rigorous trials on safety and efficacy are lacking and there is limited formal quality control but the chemicals used may be of plant, animal or synthetic origin and are the same oestradiol, oestriol and testosterone found in TGA registered tablet and transdermal formulations. There is concern that 'bio-identical' progesterone may not adequately protect the endometrium and cases of endometrial cancer in patients using these hormones have been reported.

In its latest education program, *Therapeutic choices for menopausal symptoms*, NPS advises that oestrogen with or without progestogen hormone replacement therapy is the most effective treatment for menopausal symptoms, if a decision is made to use drug therapy.

The therapeutic program reinforces the following:

- Discuss a woman's goals and concerns about menopause and her treatment preferences
- Oestrogen with or without progestogen is the most effective treatment for women with menopausal symptoms
- Consider potential benefits and harms and assess cardiovascular risk
- Tailor the dose and duration of therapy according to individual symptoms and existing risks
- Inform women about the limited efficacy and safety data on complementary and alternative medicines

As part of the therapeutic program, NPS provides health professionals with:

- NPS News (64) - *Therapeutic choices for menopausal symptoms*
- Case study (59) - *Optimising quality of life during menopause*
- Prescribing Practice Review (47) - *Therapeutic choices for menopausal symptoms*
- One-on-one educational visiting by NPS facilitators
- Small group discussions led by NPS facilitators

*For more information contact NPS on (02) 8217 8700 or email [info@nps.org.au](mailto:info@nps.org.au). For more information on the program contact Therese McGuren at the Armidale office of NEDGP 67711146 [tmcguren@nedgp.org.au](mailto:tmcguren@nedgp.org.au)*



National Prescribing Service Limited

## Prostate Cancer-to test or not to test, that is the question.

Prostate cancer is now the most common notifiable male cancer and second most common cause of cancer death after lung cancer. Prostate specific antigen (PSA) testing can help detect prostate cancer while it is still localised to the prostate and when a range of potentially curative surgical and radiotherapy treatments are still available. Treatment for localised prostate cancer has been shown to improve survival. Concerns about PSA testing centre on the low positive predictive value of an abnormal result (30% in some studies), significant number of false negatives, and the high chance of detecting some prostate cancers that will never be a threat (over detection).

*Alan MF Stapleton, Reprinted from Australian Family Physician Vol. 37, No. 1/2, January/February 2008*

Routine screening for prostate cancer with digital rectal examination (DRE), prostate specific antigen (PSA) or transabdominal ultrasound is not recommended. Patients should make their own decision about being tested for prostate cancer after being fully informed of the potential benefits, risks and uncertainties of prostate cancer testing (C). Where a patient chooses to be tested, both PSA and DRE should be performed.

Prostate cancer risk		
Who is at higher risk of prostate cancer?	What should be done?	How often?
<b>Average risk</b> The risk of developing prostate cancer increases with age. However, because prostate cancer is usually slow growing, men over 75 years of age, or with a life expectancy of less than 10 years, are at reduced threat of dying from a diagnosis of prostate cancer. Men with uncomplicated lower urinary tract symptoms (LUTS) do not appear to have an increased risk of prostate cancer. The most common cause of LUTS is benign prostate enlargement. Early prostate cancer often does not have symptoms	Inform patients of risks and benefits of screening	Opportunistically
<b>High risk</b> <ul style="list-style-type: none"> <li>Men with one or more first degree relatives diagnosed before the age of 65 years</li> <li>Men with a first degree relative with familial breast cancer (BRAC1 or BRAC2)</li> </ul>	Inform patients of risks and benefits of screening	Opportunistically

Prostate cancer PSA	
Not recommended	Justification
PSA	Whilst there is currently good evidence that PSA screening can detect early stage prostate cancer when curative treatment can be offered, it can also lead to 'over detection', ie. detection of disease which will not impact on the health of a man during his lifetime. There is inconclusive evidence that such early detection can reduce mortality. (There are two large studies currently designed to address this question due to report in the next 5 years.) Testing and treatment for prostate cancer can cause substantial harm, including erectile dysfunction (20–70%) and urinary incontinence (15–30%)

Taken from RACGP guidelines on testing for Prostate cancer  
[www.racgp.org.au/prostate/nationalguidelines/](http://www.racgp.org.au/prostate/nationalguidelines/)

### PSA Testing & Medicare

As of May 2009, men who wish to get PSA testing through their GPs can claim the cost of the test on Medicare as follows:

**66659** Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow-up of a PSA result which lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (Item is subject to rule 25) **Fee: \$37.40 Benefit: 75% = \$28.05 85% = \$31.80**

**66660** Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result which lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L - 4 of this item in a 12 month period. (Item is subject to rule 25) **Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15**



# The Link

Improving Health in the New England Through General Prac-



CPD 2010 Calendar April- June		
Event Details	Venue	
Monday 19th/ Tuesday 20th April	CPR updates with Wayne Townsend	NEDGP Armidale/ Glen Innes, 6.30pm
Tuesday 27th April	Optimising management of patients with Stable Angina who are symptomatic- which test, which intervention- presented by Dr Sergio Alvarez Diez	Quality Hotel Powerhouse, Armidale, 6.30pm
Wednesday 5th May	Bariatrics Overview- Presented by Dr Nigel Peck	Moore Park Inn, Armidale, 6.45pm
Saturday 8th May	Abuse and Violence- working with our patients in General Practice- Presented by Sabine Aitmann	NEDGP- Armidale, 8.30-4.30
Saturday 13th May, Sunday 16th May	Advanced Cardiac Life Support- Presented by STEMI	NEDGP offices - Armidale and Glen Innes, 8.30-4.30
Friday 28th May	Electromyography (EMG) in General Practice- an EMG / Nerve Conduction Study- Presented by Dr Melinda Pascoe	Moore Park Inn Armidale, 6.30pm
Tuesday 1st June	ECG workshops for Practice Nurses and GPs- Presented by Becky Broomfield	NEDGP Armidale, 6.30pm
Wednesday 16th June	ECG workshops for Practice Nurses and GPs- Presented by Becky Broomfield	NEDGP Inverell, 6.30pm
Thursday 17th June	ECG workshops for Practice Nurses and GPs- Presented by Becky Broomfield	NEDGP Glen Innes, 7.30am
Tuesday 18th May	Mind the Gap Physical and Mental Health Co-morbidities- Presented by Carolyn Croft	NEDGP - Armidale, 6.30pm
Wednesday 9th June	Chronic Renal Failure, Hypertension, what GPs need to know- Presented by Dr Stephen May, Dr Helen Lammi	Boolimimbah, UNE, 6.30pm
Thursday 10th June	Infection control and sterilisation techniques- Presented by Lin Lochead	Quality Hotel Powerhouse, Armidale, 5.30pm
Wednesday 23rd June	Secondary Lymphoedema- Presented by Trish Allen, Lymphoedema practitioner, Mt Widge Hospital, Sydney	NEDGP- Armidale, 6.30pm

The Rural Health Education Foundation (RHEF [www.rhef.com.au](http://www.rhef.com.au)) will be running a series of webcasts and satellite broadcasts including:

PROGRAM	TIME
<b>End of Life Care: Sharing solutions</b>	13 <sup>th</sup> April 2010, 8.00pm 16 <sup>th</sup> April 2010, 12.30pm
<b>Indigenous Communities tackling Chronic Disease</b>	27 <sup>th</sup> April 2010, 8.00pm 30 <sup>th</sup> April 2010, 12.30pm
<b>A Finger on the Pulse: Acute Coronary Syndromes</b>	11 <sup>th</sup> May 2010, 8.00pm 14 <sup>th</sup> May 2010, 12.30pm
<b>A Program on Prostate Cancer and Depression</b>	18 <sup>th</sup> May, 2010 8.00pm 21 <sup>st</sup> May 2010, 12.30pm
<b>Caring for Carers: Depression, Anxiety and the Impact of Caring</b>	29 <sup>th</sup> June 2010, 8.00pm 2 <sup>nd</sup> July, 2010, 12.30pm

ASPREN (The Australian Sentinel Practices Research Network) is part of the Commonwealth's bio-surveillance strategy for preparedness for emerging diseases. Data collected by ASPREN acts as an early warning system in the event of an influenza-like illness outbreak. We are calling for **expressions of interest from General Practitioners** across Australia, particularly in rural and regional areas, to increase the number and representativeness of ASPREN General Practitioners Australia wide. Participating GPs will be eligible for CPD category 1 and 2 points as well as a fortnightly update. For information contact [monique.chilver@adelaide.edu.au](mailto:monique.chilver@adelaide.edu.au) Tel: (08) 8303 7583 or fax 08 8303 3511

We are seeking feedback from our members about the 'The Link'.  
Please contact the Division with any comments you may have.

## Skin Cancer Short Courses and Conference

The next University of Queensland / HealthCert basic to advanced skin cancer courses will be held on the Gold Coast, QLD.

### 19-20 June Certificate in Primary Care Skin Cancer Medicine

Dermoscopy, Pathology, Wound Management, Basic Practical Surgery, Medicare Billing, Business Workflow. Presenters: Prof. David Wilkinson, A/Prof. Hamish Foster, Dr Simon Clark, Mr Paul Elmslie

### Certificate in Primary Care Skin Cancer Surgery

Intermediate Course, Elliptical excisions, effective wound closure & management, skin lines, graft & flap principles. Presenter: Dr Sharad P Paul

### 26-27 June Certificate in Advanced Dermoscopy & Dermal Imaging

Advanced pattern recognition, Acral & Facial lesions. Presenters: Profs. Giuseppe Argenziano & Iris Zalaudek

### Advanced Skin Cancer Surgery Workshop

New Head & Neck Focus - lesion excision, wound closure, appropriate flaps. Presenter: Dr Sharad P Paul

Next course information:  
[www.skincancercourses.com.au](http://www.skincancercourses.com.au)  
Master of Medicine:  
[www.skincancermasters.com](http://www.skincancermasters.com)  
Skin Cancer Conference:  
[www.skincancerconference.com.au](http://www.skincancerconference.com.au)