GP*Speak*

Winter 2020

Sign of the times... coronavirus crisis

GP education brought ‘in-house’

Telehealth takes off

Quarterly magazine of the Northern Rivers Doctors Network

GPSpeak

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Sign of the times

ON THE COVER:

Readers will not be surprised to see that this Winter 2020 issue is dominated by stories related to the COVID-19 pandemic that emerged just after the previous issue of GP Speak was published (rendering our cover photo and associated story on upcoming regional theatre shows almost obsolete).

As new information about this virus seemed to emerge almost daily we have not attempted to offer a timely commentary, nor predictions about how things will turn out. Instead we have aimed to provide some local perspectives on a disease whose impacts will continue to influence social, professional and governmental behaviour for the indefinite future.

Cover photo: Sign of the times... the Alstonville showground and camping area was one of many local businesses to close after travel restrictions and social distancing laws came into force.

Editorial

David Guest
Clinical Editor

Nothing says "we're all in this together" like "pandemic".

The 1918-19 (misnamed) Spanish flu killed 50 million people world wide. A century later Covid-sars-2 has killed about 350,000 people worldwide to date. It may well be early days but a combination of improved medical knowledge, public health systems and communication technologies have largely managed to contain the rapid and extensive spread of this new disease - so far.

In the past four months we have been exposed to new terminology that has spread faster than the virus itself. We have adapted by donning more PPE (and washing our hands to the point of dermatitis for some). Working from home, a.k.a. WFH, has been embraced by many organisations and individuals, and the verb "to zoom" has gained an additional meaning. "Social distancing", "shelter in place" and Covid-19 itself are now part of the lexicon. Talk of Ro incurs flashbacks to our days of high school maths and logarithmic graphs. Australians speak of how they have adapted to being in "Iso"

The virus, formally known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), is no longer even "novel". We have lived and breathed its name for what seems like forever, although actually only a few months.

Australia's response to the Covid-19 pandemic has been very successful. Our island status and world renowned (if at times reviled) Border Force has restricted the import of large numbers of overseas cases. After a few early hiccups Australia's public health authorities and swift government action flattened the curve and within six weeks cases were restricted to less than 20 per day nationally.

Australia, like many countries around the world, has a sophisticated public health system that is constantly monitoring the spread of infection through the population. The excellent work of these public health practitioners goes unsung and it is a testament to their success that they are largely unknown to the general public.

Dr Anthony Fauci is a lead member of the White House Coronavirus Task Force and has achieved worldwide prominence in recent times in what is acknowledged to be a difficult role. Prior to this his name will be familiar to a generation of medical students as one of the authors of the last few editions of Harrison's Principles of Internal Medicine. Dr Fauci will turn 80 in December.

Australia's Chief Medical Officer, Brendan Murphy, after a long career in clinical medicine, became the first medical practitioner to become Secretary of the Department of Health on 1 March 2020. He was immediately thrown into the fray responding to the Covid-19 crisis.

NSW Chief Health Officer Dr Kerry Chant is already well known on the North Coast from the time of the fluoride wars in 2013, as covered by GPSpeak. In the early days of the Covid-19 crisis she was working 14-hour days, 7 days per week and even pulling a few all-nighters, a schedule more associated with junior doctors than from those at the top. Dr Chant's 2017 Welcome to Viruses in May presentation highlights the constant background work done by the public health physicians in preparing for the worst.

As Director of North Coast Public Health, Paul Corben has been coordinating the regional response. The area has done very well, with only low numbers of Covid-19 positive patients and the unit focuses on containing hot spots by identifying and isolating any carriers (page 19). However this is only the first phase of the pandemic and there are months of work ahead as the public health restrictions are eased.

Dr Brian Hughes is the Director of the established-for-purpose Fever Clinic at Lismore Base Hospital. On page 20 he outlines the approach that has been taken by the Northern NSW Local Health District in identifying and managing patients at the clinic and considers some possible future scenarios for containing the infection's spread.

In a war zone first they send in the surgeons, then the GPs and later the psychologists. The Federal government recognised the risks to mental health early in the pandemic and has instituted a $74 million package over the next 15 months. The loss of self-worth from unemployment has affected hundreds of thousands of Australians. The risk of suicide and domestic violence is increased. On page 15 Dr Bronwyn Hudson reviews domestic violence in the Covid-19 era and provides links to the extensive local and national support services which can be found on our website.

Substance abuse and problem gambling have also increased as a result of the societal changes brought about by the Covid-19 pandemic. On page 18 Dr Hudson notes that services are still available for patients even though face to face counselling has been restricted and some of these services have become available through the Federal mental health package.

"Never let a good crisis go to waste." This advice has been enthusiastically taken up by the alcohol industry as editor Robin Osborne reports on page 17. Targeted advertising to the vulnerable is facilitated by social media and largely flies under the radar of the health authorities and general public.

For the last eight months North Coast General Practice Training had been delivering education to all members of the primary health care sector from Tweed Heads to Port Macquarie. They ramped up their existing infrastructure in the course of only a few months and judging by the feedback were very effective educators. With the shutdown of face to face meetings they pivoted to an online webinar format that was also well received, as we report on page 16.

It was therefore with some surprise that

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Editorial

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the North Coast Primary Health Network announced in late April that they would not be renewing the contract with NCGPT. On page 7 we recount the recent history of education on the North Coast under the Federal Government's contracting model and on page 5 Julie Sturgess, CEO of the NCPHN, outlines the plans to integrate education into their overall health strategy for the North Coast.

Long time Coffs Harbour GP and educator, Dr Nicola Holmes, has resigned in protest over these changes. On page 9 she describes the success of NCGPT's programs in the past and notes that successful programs do more than just impart facts. She concludes by challenging the NCPHN to maintain the quality of education previously provided by NCGPT.

Few countries have bettered Australia's medical response to the pandemic. As with the 2008 Global Financial Crisis the advice from the experts to the government was "go early and go hard".

Viewed in health terms this has proven to be a successful strategy but the economic costs have been huge. Some believe the regulations have gone too far and oppose mandatory restrictions on economic, libertarian or even philosophical grounds. Others note that the economic repercussions of lockdown also have health effects as discussed in this issue.

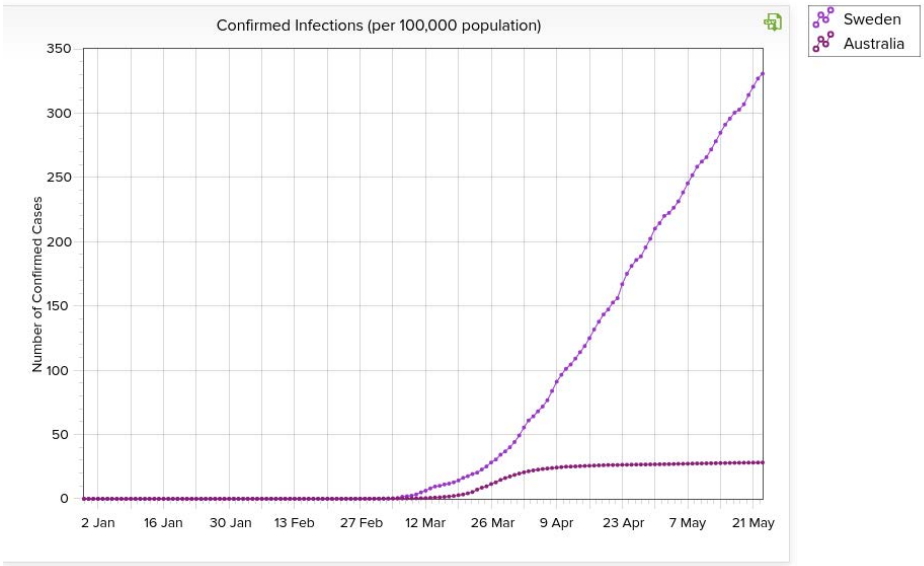
At the time of writing Australia is starting to ease restrictions on the size of gatherings and travel. Screening, contract tracing and other public health measures remain crucial to containing the pandemic but we must proceed with caution. Singapore experienced a second wave of infection amongst its lower socioeconomic migrant workers when they relaxed their restrictions.

Sweden is most notable amongst OECD countries for following a modified herd immunity approach to the pandemic. There have been no formal restrictions on activities apart from keeping gatherings to under 50 people. Business continues as usual but is quieter, with everybody undertaking precautions. There is increasing working from home where this is feasible. However, Sweden's infection rate is currently amongst the highest in Europe although their cumulative deaths have not yet reached those of England, Spain or Italy. Most of the deaths have occurred in the over 70 age group. There is no flattening of the curve at this stage.

How the pandemic plays out in Sweden, Australia and countries using other models for management of Covid-19 makes a fascinating study. However, as I approach the twilight of my career I am glad that I live in Australia and not Sweden. "Boomer remover" is a common nickname given to the virus by millennials and Gen Zers, which I find unsettling, personally and ethically.

Similarly disappointing has been China's initial reaction to requests for an objective investigation into the transmission source/s of coronavirus. While international pressure now seems to have encouraged cooperation from Australia's prickly trading partner, time will tell how much access is granted, as well as what impact all this will have on the flawed WHO.

Covid-19 has been a catalyst for many changes, nationally and globally, and we've not seen the last of them. Meanwhile, only the most optimistic would be considering booking overseas trips in the foreseeable future.



Cafe Kringlan in Haga, Gothenburg, Sweden - Photo by **Heather Cowper from Bristol,** UK / CC BY (https://creativecommons.org/licenses/by/2.0)

North Coast primary care education goes 'in house'

by Julie Sturgess

Chief Executive, Healthy North Coast Ltd (North Coast Primary Health Network)

North Coast Primary Health Network will be bringing its education program back in-house from July 2020 onwards. Clinical societies and nurse networks will continue to be supported, as will high quality, region-wide multidisciplinary workforce development.

Over the years, different models have been used to provide high-quality local education to primary health care professionals on the North Coast. Some models have grown organically through the ingenuity and commitment of local clinicians, such as those instrumental in setting up the Richmond Valley Clinical Society in 1984 and the Ballina Byron Clinical Society in 2014. Pharmaceutical companies regularly host and sponsor events locally. The majority of local education provided to local GPs, nurses and allied health professionals, however, has been funded federally.

Delivery agents have included GP training organisations, and federal and state bodies that visit locally on occasions, including RACGP, ACRRM and the NSW RDN. In addition, the Divisions of General Practice, North Coast Medicare Local and now North Coast Primary Health Network (NCPHN) have also had a strong focus on GP, nursing and allied health professional education across the North Coast.

Julie Sturgess, NCPHN Chief Executive.

In 2017, with support from local primary health care clinicians, NCPHN supported the establishment of the Casino and Kyogle Clinical Society and the Clarence Valley Clinical Society, along with the existing clinical societies already in place. Four primary care nurse networks were also established in 2017 across the Northern Rivers, Tweed, Coffs Harbour and Hastings Macleay regions. On average, around 3,000 primary health care professionals attended these and other education events every year, hosted by the PHN.

In 2018, a decision was made by the NCPHN Board to work with an external provider to deliver the workforce development program. This decision was made due to restrictions to funding that hampered NCPHN's ability to deliver the program in-house. An open and competitive procurement process followed, with North Coast GP Training (NCGPT) being awarded a one-year contract in 2019. The contract included enhancing the clinical society model across the region.

For the past seven months, NCGPT has delivered high-quality education events across the region. It is fantastic that there are now active clinical societies operating in Tweed Heads, Coffs Harbour and Kempsey in addition to those that were already established.

Ongoing changes to funding pools mean that from 1 July 2020 onwards, NCPHN will bring education back in-house and deliver it directly. This changed approach recognises the critical role that education plays in enabling PHNs to successfully engage clinicians, support the delivery of high quality health care and create a more effective health system. This is an exciting possibility, and one we believe will allow us to deliver not only exceptional CPD but better alignment with all other PHN initiatives, such as general practice quality improvement and HealthPathways.

The NCPHN Board and Executive Team thank NCGPT for the delivery of the workforce development program this year. We know from feedback that the clinical community has been most appreciative of their dedicated focus on training and the professional calibre of the content and clinical involvement.

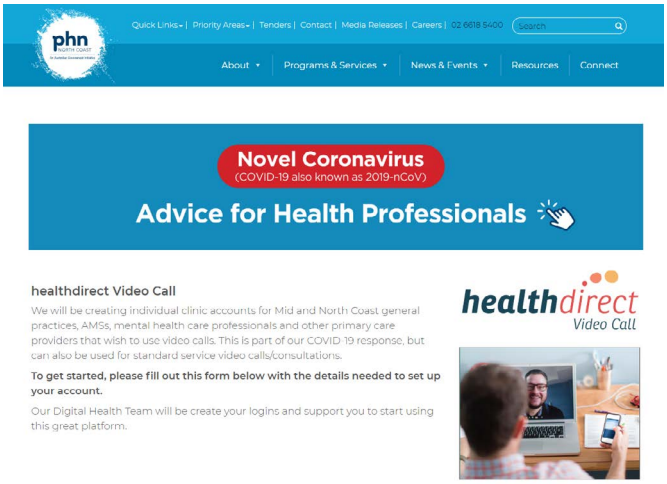
We remain committed to supporting the multidisciplinary clinical societies and nurse networks. We look forward to working collaboratively with local clinical leaders in delivering events from July. Clinical educators will be recruited, and an advisory committee will provide input on learning needs and educational topics. We will also develop an outcomes-based framework to ensure that we are on the right path and that our communities, as well as clinicians, are benefiting from the program.

The workforce education program is at the core of the ongoing work that the PHN is delivering. Please be assured that involvement and input from our local workforce is paramount in developing and delivering the program into the future.

We look forward to your engagement and contributions to ensure the best outcomes for the workforce engagement program, and, ultimately, the contribution of that program to achieving our goal of 'healthy people in North Coast communities'.

Telehealth wins with GPs, patients and government

The combination of the distancing requirements of COVID-19, the extension of Medicare to cover telehealth and continuing improvements in technology have created one of the major changes in primary care delivery in modern times. Seemingly, the changes have happened overnight, although preparations have been in train for some time, with the unexpected (in many, but not all quarters) appearance of COVID-19 simply jump-starting the process.



GPs, patients and the federal government have all shown enthusiasm for the conducting of phone and video appointments, when appropriate, and a spokesperson for Health Minister Greg Hunt says Canberra wants the treating of patients by online or mobile phone technology to be part of the "post-COVID-19 world".

Local statistics gathered by the North Coast Primary Health Network (NCPHN) show more than 80 of 101 surveyed practices now offer phone or video appointments. While high, this is surpassed by the national GP uptake, with a RACGP survey of almost 1200 practices finding 99 per cent of them offering consultations via phone or video.

This suggests a "long-term future for telehealth", Minister Hunt added.

RACGP president Dr Harry Nespolon said telehealth provides "efficient effective care in about 40 per cent of cases... doctors like it, patients like it.... Some consults can be done easily over the phone".

Between mid-March and mid-May close to five million people received around eight million telehealth services.

All North Coast practices are still offering face-to-face appointments, according to the NCPHN, and these were the main form of appointment for 15 per cent of patients. However, other GPs had moved to a 50-50 telehealth and face-to-face mix.

Phone appointments were found to be the most commonly used telehealth mode (87 per cent) on the North Coast, with the remaining 13 per cent of usage employing a combination of phone and video appointments.

"While some GPs (15 per cent) are not yet offering video appointments, we are keen to work closely with them to help resolve any barriers," said Julie Sturgess, NCPHN Chief Executive.

"We continue to provide ongoing support to health professionals who are already offering video appointments, including allied health practitioners. Real-time video is the next exciting step in interactive patient appointments, and we are pleased to offer this hands-on support at no cost.

"Our Digital Health team has a lot of experience in implementing the healthdirectVideo Call platform and can identify and resolve most issues."

Since mid-March, NCPHN has supported 135 health services from Port Macquarie to Tweed Heads to set up video appointments. To date, 2,484 video appointments have been conducted via the platform, with mental health services being among the most enthusiastic adopters.

"This is a great success story and a win-win for health professionals and their patients," Ms Sturgess said.

For more information or to get help to set up healthdirect Video Call appointments, visit: **https://ncphn.org.au/healthdirect-video-call**

Or email: **digitalhealth@ncphn.org.au**

Neurological Services return to the North Coast

After a gap of four years neurological services have returned to the North Coast.

This is welcome news for local GPs and their patients who had been forced to travel to the Gold Coast for basic neurological services. It will be particularly welcome to orthopaedic and general surgeons evaluating carpal tunnel and other upper limb neuropathies.

Dr Sue Baumann has relocated from Melbourne where she undertook a neurophysiology fellowship in nerve conduction studies and electromyography at the Austin Hospital. She has also completed a Doctorate of Philosophy in motor neurone disease at the University of Queensland.

In addition to her research in peripheral neuromuscular disorders, she cares for patients with multiple sclerosis, Parkinson's disease, epilepsy and cerebrovascular disease. She has a special interest in the management of migraines and offers botulinum toxin injections for the treatment of this condition.

She performs nerve conduction studies at St Vincent's Private Hospital, Lismore. An EEG is not offered at this juncture.

GPs can refer patients to Dr Baumann by faxing a referral to her rooms or by sending the referral electronically through the Medical Objects system. Patients are triaged and then contacted directly by her service.

GPSpeak welcomes Dr Baumann to the North Coast and appreciates this much needed addition to the clinical services in our area.

NCPHN takes education back in-house

In a surprise move the North Coast Primary Health Network (NCPHN) announced in late April it was taking back direct control of education for North Coast primary health practitioners.

The NCPHN Clinical Councils were not consulted about the decision to bring education back in house and a number of local doctors expressed their surprise when the change was announced. Many have felt that North Coast General Practice Training (NCGPT) had been doing an excellent job to date and were unclear as to why the decision had been made.

Previously, since July 2019, the NCPHN had contracted the delivery of the education program to NCGPT. The initial contract was for one year with the expectation of longer contracts in the future. It was acknowledged that it would take time to foster the relationships within the various groups in the primary health sector of general practitioners, GP based nurses and allied health practitioners, and between them and the secondary health sector groups of specialists, hospitals and State run community services.

NCGPT had previously had responsibility for training North Coast GPs but had lost the Federal government contract to Sydney based GP Synergy when the Federal government's competitive tendering processes were prioritised in 2015. Despite being inactive for four years NCGPT was able to tap into its network of experienced medical educators who were well respected and had enjoyed an excellent reputation within the North Coast medical community.

Under the leadership of CEO, Sharyn White, and Director of Education, Hilton Koppe, NCGPT managed to quickly ramp up a program that addressed the NCPHN's requirements. A series of seminars on dementia in November 2019 and workshops in February 2020 on the new hospital based specialty clinics were well attended with representation from all groups in both the primary and secondary health sectors.

NCGPT also showed great flexibility in the face of the COVID-19 crisis by putting together a number of webinars featuring local experts in infectious and respiratory disease, Aboriginal health care and general practice management on the topic of COVID-19 itself.

NCPHN covers the area from Tweed Heads to Port Macquarie and NCGPT managed to tailor their program to suit local needs. In the space of six months they had created six local clinical societies as well as four nurse networks as part of their localisation efforts. A further interest group for clinicians working in Aboriginal Health is scheduled to start in May.

It is understood that the programs were rated highly by attendees and that the program was coming in on time and on budget under the contract's performance monitoring requirements. Over 1000 primary health care staff have attended events since the contract commenced and attendance rates were growing strongly. Evaluation of the events has been very positive with 90% of participants rating the events of a high standard.

When it was first announced that the contract would not be renewed there was speculation that another educational group had been chosen that could provide an online experience at a considerably cheaper price. However, the NCPHN has since confirmed that they will be undertaking the educational program themselves.

Primary Health Networks were established by the Liberal / National Coalition in July 2015 to create an efficient mechanism to deliver primary health services. The model sees the Department of Health contracting with local organisations who in turn subcontract with other entities to provide primary health care services adapted to local needs and capabilities. Healthy North Coast Limited (HNC) was the successful bidder for the Northern NSW Coast contract.

Under the guidelines the PHNs retain certain core functions, defined as:-

1. maintenance of governance structures including Clinical Councils and Community Advisory Committees;

2. stakeholder relationship management and engagement;

3. supporting general practice

By bringing primary health education back under direct control HNC is aiming to fulfill the last of these three requirements. While the move is consistent with the guidelines it is a departure from the previous approach of tendering most services, an area where the NCPHN has been particularly active.

NCPHN runs three Clinical Councils across its footprint to provide local feedback on its programs. The Councils are advisory only, and while their input is valued, direction is ultimately determined by the NCPHN Board.

It is understood that the NCPHN has processes in place to continue the excellent work of NCGPT from 1 July 2020. There had been concern expressed that there would be a hiatus of 6 to 18 months in rolling out a new program as had been the experience of education delivery under NCPHN's stewardship previously.

GPSpeak looks forward to the NCPHN's program in this important area and is hopeful for a timely and even better education program under its auspices.

Dr Simon Platt

MB ChB, PGCert ,FRCS, FRCS (Tr. & Orth), FRACS (Orth)

Orthopaedic Surgeon (Foot & Ankle)

Dr Platt specialises in all aspects of foot and ankle work, including:

- Sports injuries
- Arthroscopic (keyhole) and minimally invasive surgery
- Soft tissue injuries
- Bunions
- Acute fractures
- Reconstruction procedures
- Achilles tendon surgery

For more information contact:
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Gold Coast Private Hospital
14 Hill Street, Southport QLD 4215
Phone: 07 5530 0770

Save The Date

Online Event – Thursday 11 June 2020

"Everything a GP needs to Know about Bunions (Hallux Valgus)"

Further information and registration contact Narelle Morrison:
narelle.morrison@healthscope.com.au

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'All-inside' technique helping patients kick chronic ankle instability

Dr Simon Platt is one of only a handful of orthopaedic surgeons in Queensland performing an all-inside ligament reconstruction to help patients suffering from chronic ankle instability get back into the sporting arena.

The foot and ankle specialist, who recently joined Gold Coast Private, said the less invasive technique, known as the ArthroBrostrom, resulted in less wounds, swelling and scaring than the more traditional approach to surgery.

The ArthroBrostrom is an arthroscopic lateral ligament repair to the anterior talofibular ligament (ATFL), using arthroscopic portals and an additional small incision.

Dr Platt said his usual practice was to scope the ankle during the procedure.

"There is often debris in the ankle and we have published and presented research that shows this is typically pain-generating and may cause problems later, even if the ankle is stabilised," he said.

"The ArthroBrostrom allows you to scope the ankle and, at the same time, do the ligament reconstruction through the scope.

"There is a much smaller incision involved than with the traditional technique, so it is quite a 'neat' procedure."

Dr Platt said patients would wear a moon boot for four weeks following the day-case surgery.

"Their wound will settle over the next 10 to 14 days, with gentle physiotherapy beginning virtually immediately and increasing at around the two-week mark," he said.

"They will be back to playing sport in about six to nine months.

"The ArthroBrostrom technique doesn't alter the length of recovery time, but it does mean we make fewer and smaller incisions resulting in less wounds, swelling and scaring.

"At the same time, it is as strong as the traditional technique, if not better."

Dr Platt said the procedure was life-changing for patients.

"Every time you roll an ankle it is painful, so those who suffer from chronic ankle instability tend to become quite apprehensive and avoid any activities that may provoke that movement," he said.

"Often they have sporting aspirations, whether that is at a professional or recreational level, and their ability is affected by this apprehension - they go from being quite active to not doing much for fear of rolling their ankle.

"Patients tend to be younger, sporting people, but those of any age with recurrent sprain or instability in the ankle are a candidate for the procedure."

Dr Platt said those who played sports such as soccer, basketball and netball were more susceptible to suffering from repeated sprains.

"Generally they have tried physiotherapy and failed to get better," he said.

"It is a very unpleasant condition to have, so to repair it - by any technique - improves quality of life.

"Once the reconstructive surgery is done, it gets them back to sport and back to activity, but most importantly gets them back to day-to-day life without the fear of going over on their ankle."

Changes to education on the North Coast

Editor's note: Dr Nicola Holmes is a GP in Coffs Harbour. She works at the Coff Harbour Medical Centre and worked in the past for 10 years at Coffs Harbour Headspace. She has been involved in GP registrar training for over 10 years and teaches with the Black Dog Institute in the area of mental health training for doctors. She was a member of the Mid North Coast Clinical Council of the North Coast Primary Health Network but resigned recently in protest over recent changes to the NCPHN's education program.

Most GPs in the NCPHN footprint were surprised and disappointed to find NCGPT has not had its contract renewed by the NCPHN to continue delivering education to medical, nursing and allied health staff in our footprint.

Unfortunately, this decision will come with loss of goodwill and talented staff from a highly effective medical education provider, and loss of trust in the process by medical practitioners in our local area. The ultimate fall out of this decision will be evidenced over the next 12 months.

Education is core to providing healthcare in our area. Think just recently how much information and education we have all had to absorb regarding the responses needed to combat Covid 19. There are many ways of delivering information, and with Covid much has been supplied via websites, written material, and regular update emails. This style of teaching is completely effective in emergency situations such as the current pandemic. Governments and NCPHN should be congratulated in their responses to the pandemic.

Ongoing medical education of the workforce, and keeping a sustainable, healthy, non-burnt out workforce requires a totally different approach to education than an emergency pandemic.

Having worked for NCGPT for 10 years previously, as a medical educator for registrars in our region, I know first-hand that the philosophy of NCGPT goes much further than providing facts in a timely manner. NCGPT always focussed on sustainable workforce, prevention of clinician burnout and subsequent drop out of the profession. They have worked on scaffolding clinicians with support within their local professional community. Initially among GPs and specialists, and more recently as evidenced by their education program under the NCPHN fostering relationships and connection between a wide range of disciplines such as nursing, physiotherapy, dental, occupational therapy, psychology as well as starting the slow process of building a bridge of relationship between primary care and the LHDs.

This philosophy adopted by NCGPT made it the most unique and enjoyable workplace to be part of.

I am not confident that the NCPHN can deliver a similar standard of education in house as was provided by NCGPT.

I would be thrilled to be proven wrong in this belief, and will watch intently from the sidelines to see how the next year unfolds. I encourage all of the GPs in the NCPHN to hold NCPHN responsible for this decision regarding our education and hold them accountable should they not deliver on their promises.

SCU's new health head feels "safer in Australia"

Southern Cross University has appointed a new Head of School of Health and Human Sciences to replace the long-serving head Prof Iain Graham. Arriving amidst the COVID-19 lock-down in the UK, where she was based at the University of Hull, Professor Julie Jomeen is now safely in the Northern Rivers and ready to take on the multi-campus role in Lismore, Coffs Harbour and the Gold Coast.

Professor Jomeen is a distinguished researcher and an experienced Dean, as well as a mother of two children. Her daughter has accompanied her and her son will join them when the travel restrictions have eased.

"Things back home were just starting to move into crisis stage with COVID-19 when we left. And it was strange when we got to Australia - it was straight into lockdown. Two weeks of isolation was not what I expected, but it was understandable.

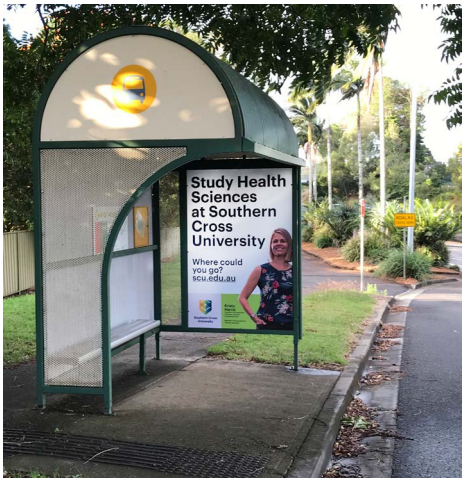
"It is very difficult at home; I keep in touch regularly with family and friends."

Professor Jomeen praised the Northern NSW Local Health District's proactive approach to COVID-19, emphasising the important role of frontline health workers.

"I felt a sense of safety and stability in Australia compared to the UK," she said.

"It has been a surreal start to this role, however every crisis creates an opportunity and the importance of the healthcare workforce has never been more dominant than it is right now on the front lines. This demonstrates the value of university health research and industry-ready graduates to ensure the best possible workforce for delivering the best possible care.

"The vision of our school is to strengthen relationships and partnerships within our health districts and the broader healthcare sector, to be part of healthcare workforce solutions and give students excellent placement experiences."



Professor Jomeen's passion for delivering the best outcomes for health professions comes from her extensive clinical experience as a nurse and midwife as well as leadership roles as Dean of Health and Social Care and Dean of Health Sciences, incorporating sports health and exercise science, psychology and biomedical science.

Zoom, zoom, zoom

by David Guest

The Covid-19 pandemic has brought about the greatest dislocation to Australian society since World War 2. Changes to work and life have affected all sections of the community and have required wholesale changes to the way we live our personal lives and undertake our work

Restricting virus transmission has been the key to Australia's success in **flattening the curve.** Unfortunately the required isolation has left many people out of work, creating hardship and immense personal distress, with some industries even having to shut down completely. The arts have been especially hard hit, and despite the innovative move to 'virtual' performances from performers' homes, thousands of talented artists have been left high and dry, with scant government support. Nevertheless, many aspects of society have kept functioning - medical practices, banks, alcohol retailers.

In the last three months the shift to online services has created major changes in education, retail, hospitality and the law. **Government services** have managed to improve their online presence and even the national cabinet has seen value in moving to online meetings to replace the often fractious COAG meetings with the State premiers.

The church has also adapted. The **Easter mass** at the Vatican was live-streamed and in the Northern Rivers you can attend **mass online** where attendances have been booming.

Perhaps the most telling sign of the times can be found in the May **In Touch** newsletter of the Queensland Government's, Prostitution Licensing Authority, where readers are reminded that close personal contact is prohibited but "sole operator sex workers may continue to provide online or phone services, such as video streaming or phone chat."

Even in the technical backwater of medicine, where the fax machine still rules supreme, there has been a shift to facilitating online services. While long term reforms to the Medicare system have been in the Health Department's pipeline for years, the changes to day-to-day practice had been lamentably slow. Then suddenly, with the advent of the Covid-19 shutdown, changes happened almost overnight. Health minister, Greg Hunt, said that there has been "a decade's worth of work in a matter of days".

Medicare's rulings and payments for telehealth consultations were revised several times in the first few weeks of the pandemic. It had the feel of regulation on the run and indeed it was. However, in recognition of the need to keep both patients and general practices going, the system became progressively more generous as the days went by.

While physical examination is an essential element in clinical diagnosis and treatment for many conditions, much of our routine care can be accomplished without it. The loss has affected some disciplines more than others. Surgical work was curtailed but psychiatrists largely carried on with few restrictions.

Many patients preferred the new system. Video consultations presented a technical challenge for some older patients but the convenience and efficiency of online consultations is preferred by many. In particular, telehealth has been promoted widely for the management of **youth mental health** issues where access to face to face consultations and cost can be prohibitive.

Studies have shown that having a properly functioning video connection with the patient is superior to audio alone, and video consultations are also the government's preference for telehealth. Changes in facial expressions provide information that cannot be gleaned by voice alone. At this stage, however, there is no difference in the rebate offered by the MBS between video and telephone consultations. Nevertheless, once the Covid-19 pandemic passes, practices may find themselves incentivised to prefer video over telephone for their remote consultations.

The key elements of videoconferencing are the input and output of sound and video, speed and something to bring it all together. Microphones and speakers, webcams and monitors can range in price and quality but cheap consumer grade hardware is adequate for most purposes. The increasing availability of the National Broadband Network has made videoconferencing a more reliable platform in Australia in recent years and the codecs that compress and decompress the data streams have become increasingly sophisticated..

The first video chat clients date back to the mid nineties when **CuSeeMe** was first released by developers from Cornell University. Commercial clients followed 10 years later, including **Webex** from Cisco and **SmartCloud Meetings** from IBM. In Australia, **GoToMeeting** from Citrix was widely used in the early noughties but became less popular in recent years.

There are now literally hundreds of video chat clients that have been adapted for specific industries and uses. Some are platform restricted like Apple's **Facetime.** Others like **Skype** started on Windows but despite being acquired by Microsoft in 2011 are now cross platform. Still others are extensions to existing social media platforms like Facebook's **Messenger** and Google's **Hangouts**.

Most tech conglomerates have remote collaboration tools. In 2012 the Australian software juggernaut **Atlassian** promoted HipChat for its customers but has since sold off its IP to business software rival **Slack** and has open sourced its video conferencing client, **Jitsi**. Both of these products have carved out a place in today's business environment.

The big players Google and Microsoft have capitalised on their end user products and upscaled them for business. Microsoft is heavily promoting its **Teams** collaboration software and Google is once again trying to jump start itself into the business market with Google **Meet**.

However, the killer app in recent years has been **Zoom**. It owes its success to being easy to use, cross platform and free for sessions lasting up to 40 minutes. Recent security problems have created a new term, **zoom bombing**, where unwanted participants can crash a meeting, but the company has responded swiftly to address the problem. Best of all "zoom" is a great name. Like google and skype before it, zoom is a verb with a new meaning.

Zoom uses a dedicated client for participants but some programs leverage

the power of modern browsers to run the video chat sessions directly. **WebRTC** is available in Chrome and Firefox obviating the need for installing new software which can be a problem for less sophisticated users. This technology is also used by some Australian medical video chat clients like **Coviu** and the government supported **Healthdirect**. These programs are designed specifically for GP/patient consultations and the latter is free for Australian GPs under COVID-19 funding until 30 September 2020. On the North Coast it is **available through the NCPHN**.

Most video chat applications allow users to share windows from their desktop and have a sidebar chat facility which is also useful for exchanging links and other simple pieces of information. Many allow the sessions to be recorded. Some applications are focussed on security or meeting government laws such as Australia's privacy acts and America's health information, **HIPPA** regulations.

During Covid-19 most users have connected from home. It is therefore worth thinking about where to set up a laptop or iPad for these online sessions. There is often a lot of background noise so finding a quiet spot is the aim. It is also worth investing in a good quality headset or earbuds to reduce any echo that other participants will find annoying.

If available a home office is the best way to insure privacy and minimise extraneous factors. If your office is messy you can try using a fake backdrop that is generated by the computer software. This can work well in an appropriate room but be aware that parts of your body may disappear from the screen at times if the lighting is not right.

Many will have to make do with a spare bedroom but one with a lock is advisable. Professor Robert Kelly's 2017 BBC interview *(pictured left)* highlights the importance of having a secure space for work-related videoconferencing.

People vary in their enthusiasm for making themselves and their background look good on camera and one cannot be prepared for all eventualities, but it is wise to wear pants.

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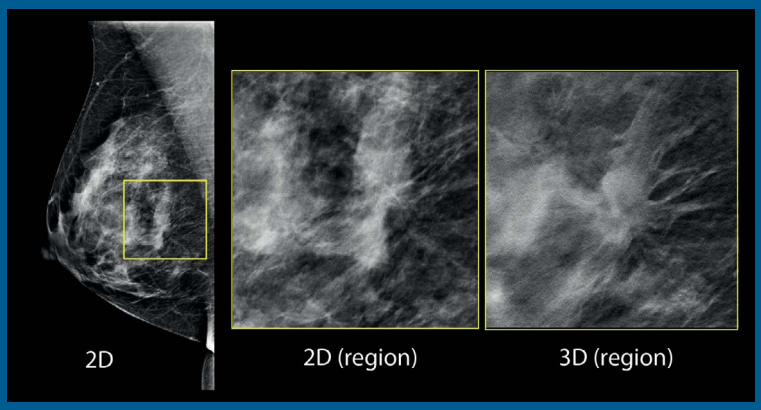

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Punishment mustn't continue beyond the jail walls

by Andrew Binns

Being sentenced to jail time means the loss of freedom for a prescribed period but the punishment can extend much longer, particularly when it comes to health and wellbeing. When prisoners are released their ongoing health needs are all too often not met.

Many will become homeless, with no choice but to sleep rough. The stats are showing this. Less conspicuous is the need for even more former detainees to bunk down with relatives or friends in often crowded households.

Old Grafton Correctional Centre (being replaced by the new Clarence Correctional Centre) - Photographer Stewart Watters CC by 4.0

Such behaviours present a major public health problem, including the spreading of blood borne viruses such as hepatitis C, not to mention the more 'novel' risk of the COVID-19 virus. Jails in Australia and (markedly) the USA are acknowledged as being high risk for spreading the coronavirus, largely because of overcrowded prisons - the two words are inevitably linked - and the resulting close physical distancing amongst inmates.

In early April in the UK the British Ministry of Justice announced plans for the early release of up to 4,000 prisoners, just under 5 percent of the prison population (although not Julian Assange). Selected "low-risk" prisoners in the last two months of their sentences will be electronically tagged and allowed back into the population to ease overcrowding.

It is also well recorded that prisoners often have co-morbidities, which increase the chances of their dying from the COVID-19 infection.

This Guardian Australia article suggests Public Health experts are warning that Australian prisons could well be the "next cruise ships" of this pandemic.

While it isn't difficult to identify these health issues it is much harder to find solutions to improve the situation under the current 'tough on crime' approach of authorities and a lack of commitment to rehabilitation. Kindness and compassion towards prisoners are often absent.

Managing people with addictions, mental health problems, and both acute and chronic disease is not easy, but there are models around the world where these matters are dealt with better than in Australia. Norway's lower incarceration and recidivism rates are a good example. That country also has an indigenous community and other disadvantaged groups.

This article will focus on three areas that would address these prisoner health concerns.

1) Develop more diversionary facilities for rehabilitation that address housing, health and employment. In our region we have the Balund-a facility, a NSW Corrective Service south of Tabulam in the Upper Clarence that is dedicated to this cause.

2) Upgrade the communication systems for safe handover of clinical care between the NSW Justice Health and Forensic Mental Health Network and primary health care teams. The current systems are outdated and inefficient. The systems now working well between the NNSWLHD public hospitals and GPs are a good model for how this could be improved.

3) If there was one way the system could improve it would be to allow inmates to have access to Medicare. This would enable them, after consenting, to have their medical history placed on My Health Record (MHR). The federal government has invested a huge amount of the health budget on this initiative but the most disadvantaged group in our community do not benefit, even though they so often suffer from ill health.

The latter is a good example of "extrajudicial punishment" that ends up biting into the health system resources with no benefit from the point of view of preventing crime. In fact the opposite may occur through the increasing of recidivism.

With the COVID-19 pandemic we have seen some fast tracking of decisions through legislation from the federal Department of Health, such as the much needed telehealth systems, particularly for rural and remote regions. The same could happen with other communication systems, such as access to the MHR for prisoners.

One barrier that is always put up is the State/Federal health system divide. Each side blames the other for inaction in these and other matters. Commonsense could break down these barriers for the benefit of all Australians, as has been show by the inter-jurisdictional collaboration on COVID-19.

Crime rates are falling anyway and removing the barriers of access to Medicare and MHR for inmates is more likely to lower, rather than raise, the crime rates within our community.

It's time to change direction with this issue. To quote US politician Rahm Emanuel: "You never let a serious crisis go to waste. And what I mean by that is an opportunity to do things you think you could not do before".

COVID-19 isolation fuelling family violence

by Robin Osborne

NSW Police data showed no major increase in reports of domestic violence during March 2020, despite the implementation of social distancing measures that experts feared would fuel violence at home, according to a report by the Bureau of Crime Statistics and Research. However, reported domestic violence related assaults began to rise in March, totalling 2678, up from 2632 in the same month last year.

However, this is only the tip of the iceberg, as ABS data shows that only half of all domestic violence is reported to police. NSW saw two murders and 35 incidents of domestic violence-related grievous bodily harm this March. Advocates warned that mandatory isolation, along with financial stress and a change in the operation of support services, would create a 'perfect

storm' for intimate partner and family violence.

'It is possible the figures are stable because isolation strategies have affected the willingness or ability of people experiencing domestic violence to seek assistance from police," the report warned.

E-Safety commissioner Julie Inman Grant said abusers may be trapping their victims at home and limiting their access to phones or computers, meaning they are unable to report abuse.

"That's a very plausible explanation for the fact that domestic violence reports have not gone up," she told The Sydney Morning Herald, encouraging victims of domestic violence to start new email accounts, turn off GPS settings, change passwords and use a separate device to the perpetrator where possible.

The Bureau's executive director Jackie Fitzgerald said social distancing provisions were only introduced for half of the month: "We haven't had long for the stresses of social isolation to take effect, and will certainly keep monitoring."

Doctor warns of COVID-19's threat to women

by Dr Bronwyn Hudson

The Yellow Gate Medical Clinic

Byron Bay, Bangalow, Lismore

There is no doubt that the COVID-19 crisis has seen an increase in the incidence of family violence. Movement restrictions aimed to stop the spread of the coronavirus are leading to violence in homes becoming more frequent, more severe and more dangerous. This is a pattern playing out around the world.

It is known that DV goes up whenever families spend more time together, such as at Christmas and holiday periods. Increases in substance use during the crisis are also a contributing factor.

While being confined to the home is difficult for everyone, the experience for victims of family violence presents more serious issues. For some, distancing rules have left them even more vulnerable.

The United Nations Secretary General, António Guterres, tweeted a post calling for urgent action to combat the worldwide surge in domestic violence: "I urge all governments to put women's safety first as they respond to the pandemic."

At the start of the pandemic, service providers reported a decrease in family and domestic violence enquiries. However, this soon took a turn to an increase in calls and internet searches relating to family violence as situations in the home escalated. Statistics from the Victorian Magistrates Court show an increase in calls to the Family Violence Contact Centre of 50 per cent in April, compared to February, before lockdowns began. There are reports of an increase of over 70 per cent of Google searches relating to domestic violence.

In contrast, calls to emergency services have dropped, as has actual access to DV services. This is an indicator of the covert forms of family violence, such as coercive control, which are also of considerable concern. Controlling behaviours have escalated, particularly in relation to victims leaving the home, financial issues and issues relating to the care of children. Isolation tactics are often an expression of family violence and community containment measures are providing a greater opportunity for this to occur.

As restrictions start to ease, it is anticipated that there will be a rush to access DV services once more.

When it comes to Family Court matters, COVID-19 has been used as a means by which opportunistic abusive partners are attempting to exert further control over care and financial agreements. There has been a 39 per cent increase in urgent applications filed in the Family Court, and a 23 per cent increase in the Federal Circuit Court over the past month. Will Alstergren, Chief Justice of the Family Court and Chief Judge of the Federal Circuit Court, announced that urgent cases relating to parenting disputes during the crisis will be rushed through Courts within 72 hours.

Frontline health professionals are well placed to screen for potential domestic violence, and are encouraged to do so, now more than ever.

Frontline health professionals are well placed to screen for potential domestic violence, and are encouraged to do so, now more than ever. It is important to be alert to all the forms of abuse and control that a perpetrator might use. Be alert for subtle cues.

Julie Gilfoyle, Solicitor, Mediator and Domestic & Family Violence Consultant, states that we need to get more creative in the ways we can keep supporting victims of DV and to escalate our identification of perpetrators during this challenging time. Part of this creativity must stem from our front line health workers as they could be the only lifeline for people affected by family violence, where the mere act of even picking up a phone can put someone at increased risk of harm.

Ms Gilfoyle goes on to say that without access to legal support, such as legal aid or other online/free legal services, the ongoing cycle of fear, and limited understanding of the rights and available services can perpetuate a woman's experience of DV. She also raises concerns about the immigrant community and certain visa holders who are ineligible for Medicare. Threats of being deported and separated from their children are not uncommon.

It is essential that we are all aware of the support services available and have a plan for how to deal with the violence, if and when it is disclosed.

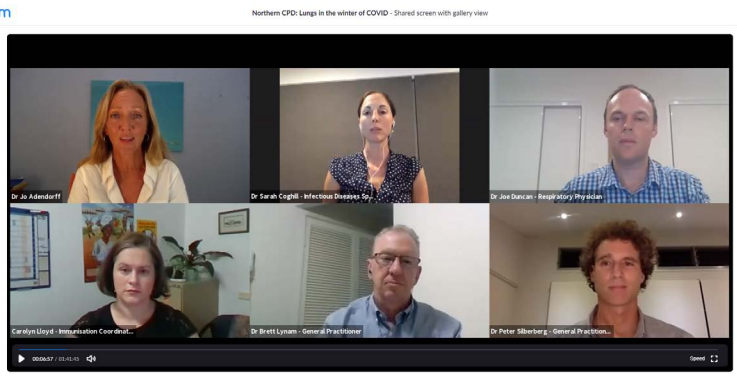
In researching this piece, one of the resounding messages that came through was that service providers are standing at the ready to service our community in the essential support of people at risk of harm.

Another side of our response is to be prepared to give assistance to the perpetrators, or potential perpetrators, if presenting patients are concerned about their own violence towards their intimate partner or family. Asking patients directly if they are concerned about their actions during these challenging times and enquiring about the safety and wellbeing of loved ones in their homes, needs to be a priority for us all. Again, having a plan should this be identified, is an important part of the strategy. The men's referral service is accessible on 1300 766 491.

National and local services for assistance with domestic violence issues can be found on the website version of the article. (Search **gpspeak.org.au** for "COVID-19 isolation fuelling family violence".)

Northern CPD Lungs in the Winter of COVID-19

On 20th April 2020, North Coast General Practice Training conducted its first online training for local GPs. Unsurprisingly, the topic for **the webinar was COVID-19.**



Drs Jo Addendorf, Sarah Coghlan and Joe Duncan (top row) and Carolyn Lloyd, and Drs Brett Lyneham and Peter Silberberg (bottom row)

The meeting was run as a case discussion led by Tintenbar GP, Jo Addendorf, with input from local GPs Peter Silberberg and Brett Lyneham on how North Coast general practice was dealing with the issue. Peter also highlighted aspects of care relevant to the Aboriginal community.

Subject matter expertise was provided by Lismore Base Hospital doctors, Dr Sarah Coghlan (infectious diseases) and Dr Joe Duncan (respiratory medicine), and by Carolyn Lloyd, Immunisation Coordinator from the North Coast Public Health Unit.

After the discussion Julie Sturgess, CEO of the North Coast Primary Health Network, joined the Q&A session. In the last three months the NCPHN has invested heavily in education and primary care provisioning for the early phases of the COVID-19 pandemic.

Julie was also joined by Dr Hilton Koppe, NCGPT lead educator, who outlined the resources available on **HealthPathways for COVID-19 management** on the North Coast.

Over 100 practitioners registered for the webinar which was well received by those attending. Its success augurs well for further online training from NCGPT and the format acts a template for future webinars.

Editor's Note:

1. The session is being replicated in the mid North Coast LHD region on 28 April, 2020. Links to this and other NCGPT webinars can be found on the their **Eventbrite page.**

2. Access to the webinars requires a password which can be obtained by emailing **info@ncgpt.org.au**.

Keep your distance, partner

On the day the NSW Government allowed the easing of restrictions on public gatherings, dining and outdoor activities, two of the key agencies involved with protecting the community from the spread of coronavirus joined forces to issue a sombre warning: "This is not over," said NNSW LHD chief executive Wayne Jones,w, agreeing with a journalist's suggestion that locals are becoming complacent about the risks of transmission.

"You only need to go to the shops to see that," Mr Jones said. Richmond Police District Crime Manager Detective Chief Inspector Cameron Lindsay added that on the previous day two people in downtown Lismore had been charged with breaching the distancing and travel rules.

On that same day, the LHD advised that two cases of COVID-19 had been confirmed in local residents, bringing the total number of cases to 57 (of whom, 51 had recovered).

Emphasising the essential public health messages of distancing, frequent hand washing, avoiding touching public surfaces

On 15 May, Northern NSW Local Health District Chief Executive Wayne Jones and Richmond Police District Crime Manager Detective Chief Inspector Cameron Lindsay demonstrated appropriate social distancing in the age of COVID-19.

and one's face, Mr Jones took obvious satisfaction from telling the media that his LHD had the highest testing rate in NSW, and given Australia's position on the world stage, this meant we have one of the highest globally.

Despite that, or more accurately because of it, "It would be naïve to think we won't see more cases," he said, adding, "This is certainly not over... [however] it's good news that we'll be able to move about more freely and catch up with our friends and family."

Chief Insp Lindsay agreed that enforcing social distancing and other compliance measures is extremely challenging for police, especially in locations such as our popular beaches. Fortunately, he said, none of his officers had contracted coronavirus.

Australians urged to grog-on during the lockdown

A report released in mid-May by the Cancer Council WA, supported by the Foundation for Alcohol Research & Education (FARE), found that in in a one-hour slot on a Friday night a total of 107 sponsored alcohol advertisements were displayed on a person's Facebook and Instagram accounts, equating to approximately one alcohol ad every 35 seconds.

Cancer Council WA Alcohol Program Manager Julia Stafford says there were six key marketing messages identified in the sample of alcohol advertisements analysed in the report:

- · get easy access to alcohol without leaving your home (58%)
- · save money (55%)
- · buy more (35%)
- · drink alcohol during the COVID-19 pandemic (24%)
- · use alcohol to cope, 'survive', or feel better (16%)
- · and choose 'healthier' alcohol products (14%).

"Over 100 alcohol ads in one hour demonstrates the relentlessness of digital alcohol marketing during the COVID-19 restrictions. Many of these ads promoted buying more alcohol and drinking alcohol to cope or 'survive' isolation and the pandemic," Ms Stafford said.

"With phrases like 'wine from home', 'Stay in. Drink up', and 'confinement sale', it's evident the alcohol industry is using a global health crisis to its advantage," she said.

Nearly three-quarters of alcohol ads (71%) explicitly or implicitly referenced the COVID-19 pandemic, while two-thirds (66%) had a 'shop now' or 'get offer' button linking directly to their online store.

FARE's CEO Caterina Giorgi says people were bombarded with unrelenting alcohol advertising encouraging people to drink at a time when people are socially isolated, feeling anxious and facing economic uncertainty.

"This study shows that alcohol companies are taking advantage of people's fear and anxiety by urging us to drink alcohol to cope with isolation. This is all happening while people's lives have been turned upside down because of COVID-19," Ms Giorgi said.

Ms Stafford says the way the alcohol industry has utilised this difficult time to market their products shows significant flaws in the alcohol industry's self-regulatory scheme in Australia, the Alcohol Beverages Advertising Code (ABAC) Scheme.

"The marketing practices of the alcohol industry during the pandemic show that the way that we regulate alcohol advertising in Australia is broken. The industry cannot be trusted to regulate their own marketing," Ms Stafford said.

Home isolation fuelling substance misuse

by Dr Bronwyn Hudson,

GP and Addiction Physician

On 27 April 2020, The Guardian reported that, "Across Australia, the COVID-19 crisis has prompted a seismic reckoning in addiction medicine". Sensationalist headline or an accurate reflection of the impact of COVID-19 restrictions on substance use?

Jokes abound on social media about increased alcohol consumption, home schooling forcing "the teachers" to drink; 9.00 am 'happy hours' and the advent of the quarantine cocktail aptly named "The Quarantini". While the jesting nature of these memes can incite a giggle, an epidemic of arguably equal force to COVID is continuing to brew. I say continuing, because these problems existed in our homes long before COVID. Social distancing and isolation measures have exacerbated an already existing epidemic.

As the restrictions placed on the community unfold, the potential for harms associated with alcohol and other drugs is increased. In the wake of other mass traumas, such as natural disasters (including the recent bushfires) we have observed an overall increase in substance use. In addition to the effect that the lockdown has had on the overall population, individual stressors such as loss of employment, home schooling, caring for vulnerable people and even just the mere uncertainty and lack of control over the situation is placing people under stress.

This stress is one of the biggest driving forces that leads to an increase in substance use.

Photo by Mae Mu on Unsplash

For people who use drugs and alcohol, reduced or non-existent supply (due to closed borders and limited travel) and limited access to drugs during the pandemic have led people to substitute their drugs of choice or to change their patterns of use. Failure to access their usual supply is forcing many into withdrawal. There has been an increased demand for opioid replacement therapy and a surge in the number of people seeking inpatient withdrawal services.

The provision of health care services, within an already overloaded system, has been challenged and health workers have had to respond quickly to the changing conditions and requirements implemented by both State and Federal Governments to prevent the spread of COVID-19. This has placed a burden on all healthcare workers, especially those who already deal with vulnerable groups. The capacity of Public Hospital inpatient withdrawal services has decreased due to social distancing requirements, and access to residential rehabilitation has virtually ceased all together. Fellowship groups such as AA and NA have moved online.

Front line health care workers are encouraged to screen for substance use disorders now more than ever and a number of screening tools are available (e.g. CAGE and AUDIT). Being aware of support services available to people who use drugs and alcohol is also important, as is timely referral to an appropriate service.

Consultation drug and alcohol liaison services exist in most Public Hospitals. The St Vincent's Hospital Drug and Alcohol Specialist Advisory Service (DASAS) is a free telephone service for health professionals in NSW to call. DASAS provides a 24/7 service which advises on clinical diagnosis and management of patients with alcohol and other drug related problems. The service is available on 02 9361 8006 (Sydney metropolitan) and 1800 023 687 (Regional and Rural NSW).

Australian States and Territories operate local alcohol and other drug telephone services that offer support, information, counselling and referral services for individuals, family and friends, health care workers and business/community groups. The National Alcohol and Other Drug hotline can be reached on 1800 250 015. This service will automatically direct callers to the alcohol and other drug information service in the appropriate State or Territory.

The show mustn't go on

by Robin Osborne

In the latest issue of GP Speak we ran a cover photo of Alstonville GP Luke Hogan performing in Ballina Players' excellent production of Wicked, The Untold Story, and a story about the wealth of theatrical shows that would be upcoming for the rest of this year. Local doctors were well represented on stages and behind the scenes.

The card for Ballina Players included the blockbusters Mamma Mia and Priscilla, Queen of the Desert, with the story more generally profiling offerings from the Lismore Theatre Company in the recently refurbished Rochdale Theatre, and the unfolding season of the Lismore City Hall based NORPA.

Such has been the impact of the Covid-19 pandemic, which, despite resolute government action and strong community cooperation, has continued to sweep across NSW, as it has the world at large, causing immense personal suffering, unprecedented (that word again) pressure on the health system, and grave economic and social consequences.

"The biggest thing in our lifetime"

North Coast Public Health Director Paul Corben reflects on the challenges of COVID-19

by Robin Osborne

A self-described "farm boy at heart", Paul Corben gazed out at the cows in the paddock of his property near Port Macquarie, on the NSW mid north coast. Like most people during the height of the COVID-19 lockdown he was working from home, but the Director of North Coast Public Health was anything but under-utilised, not least because he was not long back from a period of extended leave.

"I began leave last November and by the time I returned at the end of March it seemed the whole world had changed," Mr Corben told GP Speak.

"There has been nothing on the scale of this COVID-19 outbreak in the past century. For the public health network in NSW and Australia more widely this is the biggest thing in our lifetime.

"The fact is that we can't lock the world down on a scale for COVID-19 to burn itself out, especially as we have relatively little idea of what's happening in, say, Africa, or even as close to home as PNG."

Paul Corben and some of his cattle

He continued, "Another challenge is that the information we have about this novel microbe is changing weekly, sometimes even daily... initially we were assuming that spreaders would be symptomatic, then we discovered the risks of asymptomatic transmission, and next the possibility of pre-symptomatic transmission.

"It's an emerging knowledge base and with no vaccine on the immediate horizon the key public health measures are all the more important."

The broader community has been encouragingly quick to embrace practices such as social distancing, handwashing, cough and sneeze protocols and even the somewhat problematical COVID-Safe phone app.

"It's been pleasing to see the level of support by the public," Mr Corben said.

"The challenge is from here on as the rules are relaxed... we must appropriately ease restrictions at the lower possible public health cost."

In this age of COVID-19 the role of North Coast Public Health, whose network spans both the Northern NSW and the Mid North Coast Local Health Districts, is to "contain hot spots and minimise the virus's spread, as well as working with primary care providers to identify and isolate any carriers, and identify the source of their infection."

On the day of our interview no new cases of COVID-19 were identified on the North Coast. At 8 May 2020 there were 105 confirmed cases in the area (Tweed Heads to Port Macquarie) covered by the two LHDs. NSW totalled 3051 cases.

At face value, Paul Corben might seem like the farm boy he describes but he's actually a numbers man.

Born in Sydney, he and his ten siblings moved north to a dairy farm outside Taree when their father embarked on a radical career change. Later he did a Bachelor of Science, majoring in agricultural economics, followed by a Masters. He's currently undertaking a PhD, focusing on public health.

"I'm all about numbers," he said, "so no chance of getting a photo in a lab wearing a white coat and holding test tubes. Epidemiology is one of the pillars of my discipline."

Mr Corben moved into the public health field in 1992 during a decade-long spell with NSW Health in Sydney He moved back to the North Coast to lead a highly professional team addressing the region's challenges, including the risk of diseases spread by fruit bats, mosquito borne viruses, the occurrence of serious communicable diseases such as pertussis and measles, and vaccination resistance in a number of regional locations.

However, nothing has happened on the scale of COVID-19, and Paul Corben suspects he may not be taking another holiday for some time: "Everyone's travel plans are now on hold, and look likely to be for some time. I was lucky to have a break before all this started, now it's just go-go-go, and we can only hope for a better ending."

Addressing the key role of GPs amidst this crisis Mr Corben said practices have been doing a great job amidst rapidly changing circumstances, including patient confusion and the uptake of telehealth.

"It's certainly important to encourage testing and referring patients if only the mildest of symptoms are detected. I think it's important to remind patients that GPs are still open for business. This is a major concern, as recent figures [he's a numbers man, remember] show that demand for GP services and ED attendances have dropped by 30 per cent in recent times.

"We don't need people at home with crushing chest pain because they don't want to overburden the system. It really is important to keep in touch with patients known to have chronic diseases."

And so saying, he went back to looking at the cows, or perhaps to counting them, this being an irresistible habit.

How Northern NSW has responded to COVID-19

by Dr Brian Hughes

General Physician, Infectious Diseases and Sexual health Physician, who set up up and supervised the Fever Clinic at Lismore Base Hospital.

Versatility/Capacity

The COVID-19 action plan activated across the Northern NSW Local Health District included:

- Increasing capacity to treble the number of ventilated beds
- Using a separate ICU with negative pressure rooms
- Creating admission and assessment pathways for patients according to severity of their illness while reducing the risk of exposure to the public, staff and emergency department.
- Managing patients in the community according to severity stratification and risk factors for deterioration in Hospital in the Home (HITH) in concert with GPs.
- Managing patients using novel assessment processes (home oximeters and pulsimeters), and using markers of severity (Lactate, O2 sat, D-Dimer, Troponin, Urea, LDH, Lymphocyte to Neutrophil ratios etc.)

Strengths & Weaknesses

Lismore Base Hospital (LBH) was fortunate to have the recent addition of a new ICU and ward block that contained many single and negative pressure rooms. Old wards earmarked for refurbishment or closure were quickly turned into a possible COVID-19 cohort ward.

The old emergency department (ED) was used as the elective outpatients assessment clinic, and quickly turned into a "fever clinic" for testing for COVID-19. Its proximity to the HITH service allowed for easy assessment of patients requiring review.

A large waiting area and internal seating allowed for many to appropriately social distance. Televisions helped patients pass the time. A negative pressure room was earmarked in case a surge in the number of probable Covid-19 patients occurred.

All screened patients were logged into the electronic medical record, making. it is thus easy to admit those who returned positive swabs to HITH.

The use of a drive-in testing facility at LBH was considered but deemed impractical due to likely traffic issues near the new ED and car park.

Champions & Challenges

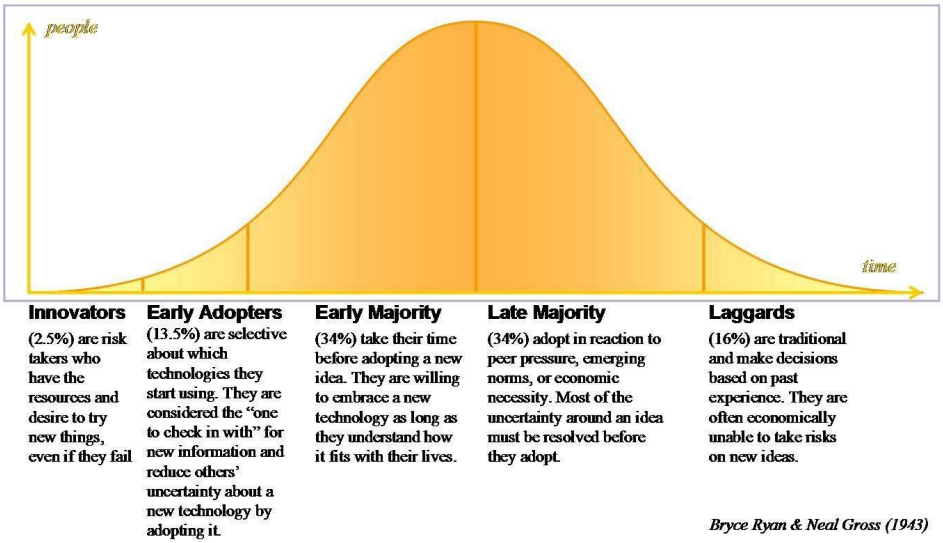
The Clinical Lead had public health and infectious diseases qualifications and previous experience in setting up screening clinics.

The traditional outpatient setting for the clinic , rather than a drive-through service, meant an increase in the amount of PPE used initially. As staffing levels increased and the clinic moved to a nurse-led model there was better use of resources and increased surge capacity.

we created written resources to reduce repeating the information given verbally.

We informed clinical staff elsewhere in the hospital that we were focussed solely on screening for COVID-19 and it was not appropriate for us to assess the cause of any fever. However, we emphasised our clinic was the right place to undertake screening noting that testing in the community is expensive and difficult due to the fact that using personal protective equipment is cumbersome and the required cleaning is time consuming.

Reconfiguration of exit bollards to protect patient transport staff and public from patients entering for review from HITH or exiting from screening was required. Donning and doffing and assessing unwell patients in their homes proved challenging. A national HITH email group and webinar



Communicating a negative result proved difficult initially because of the volume of testing and confusion by the public on recommended screening practices. SMS communication was initially trialled using the Telstra Integrated Messaging service, however the slow turn-around times from reference laboratories resulted in some false negatives. A labour intensive system offered by the Sexual Health Service was subsequently replaced with Pathology North's system, which proved to be reliable and error free.

As part of the clinic's push to increase efficiency and develop a more streamlined approach to managing the clinical load

HITH COVID-19 meetings were convened to share experiences, resources and service structures. It was comforting to learn our service structure was similar to others and we all had similar challenges.

Stakeholders & Resources

Close contact with Public Health and Pathology North ensured that all individuals with COVID-19 were assessed for risk of deterioration and were admitted to their nearest HITH program (Tweed or Lismore). The program ensured that appropriate contact tracing and testing of contacts occurred. Multiple federally-funded testing clinics were established around the area and some GP practices

"Plan for the worst. Hope for the best. Use the experience and resources for the future"

also set up COVID-19 testing clinics to service their patients. Some of these were of the "drive through" style.

Next Phase

The Australian and North Coast response to COVID-19 has been highly successful but the future course of the pandemic is unknown. We are prepared for four possible scenarios.

1. No "second wave" of COVID-19. In this scenario testing is ramped up to include sentinel asymptomatic sections of the community to monitor transmission. Antibody testing is used to assess asymptomatic transmission. This testing may transition to GP respiratory clinics which can also assess for influenza and other viral infections as part of their management of respiratory illnesses in winter.

2. Small outbreaks of local transmission. The current system identifies mildly symptomatic contacts. This too could transition to GP-based testing clinics.

3. "Second wave" hits. In this scenario the full Local Health District plan is implemented. COVID-19 HITH is utilised. GPs will look after milder cases and transition to HITH or hospital should they deteriorate. COVID-19 single rooms to be used in LBH and the separate COVID-19 ICU activated.

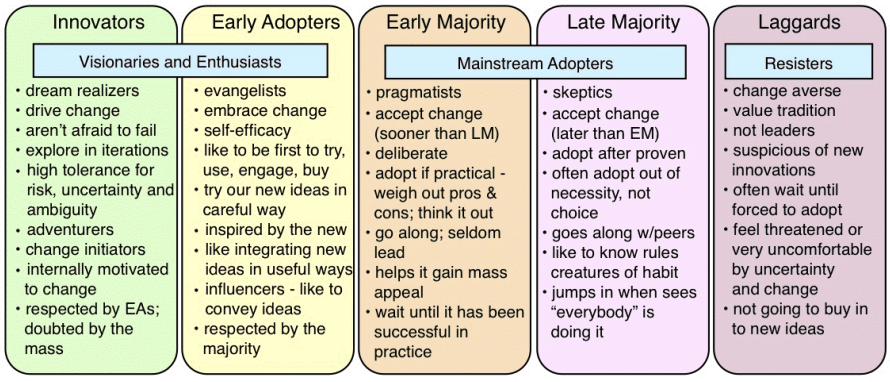
4. Major infection wave occurs nationally. Separate planned COVID-19 ward opens. Current plan is revised to cope with increased pressure on the existing model.

Covid-19 Response from Around the World

An interesting concept to apply to public health and other interventions is Everett Rogers' Diffusion of Innovation paradigm.

It is possible to think of a country's response to an epidemic using this paradigm for their compliance with social distancing and stay at home orders and their establishment of Hospital in the Home COVID-19 programs, COVID-19 screening programs and the setting up inpatient COVID-19 services.

Characteristics: Innovators to Laggards



Characteristics Image by The Center for Creative Emergence 2011
Main Sources: Diffusion of Innovation by Everett Rogers
Crossing the Chasm by Geoffrey Moore

Here is the outline of outpatient floor plan and flow for our new service at LBH.

Flow of Patients attending for COVID1-19 testing or review in HITH (see below)

1. Triage – RN or EEN triage patients on arrival.

2. Reception – Ward Clerk "naps" the "non admitted patient" in.

3. Waiting Room – after patients have been NAPed in they are asked to enter the waiting room.

4. Doctor / Nurse Consult – RN or EEN review patient and swab.

5. Bays 1 to 7 – If the waiting room fills up. Staff escort patients from the waiting room to ancillary bays for ongoing patients to enter through reception.

6. Day Stores – PPE is stored.

7. Consult Rooms 1 to 5 - Doctor / Nurse

cont on P22

How Northern NSW has responded to COVID-19

cont from P21

Consult – DR, RN or EEN review patient and swab.

8. Cleaner's Bay – Cleaner attends to areas after the patient leaves the waiting / bay seating area and the consult room before the next patient is assessed.

9. Patients exit through the side door along the barriers to the stairs.

10. HITH patients are not seen in the main clinic but enter via "the exit" after notifying staff by phone prior to entering.

Ethical Investing in a post-COVID-19 world

by Nathan Kesteven

Ethical investing, also known as Socially Responsible Investing, corresponds to a type of investment strategy which balances both financial return and social/environmental good to bring about a positive change.

Socially responsible investing (SRI) is said to have been originated by the Quakers spiritual group in 1758, when the Quaker Philadelphia Yearly Meeting prohibited members from participating in the slave trade going on in America at the time. Spiritual and religious institutions have since then been the pioneer proponents of social investing.

John Wesley one of the founders of Methodism, made a sermon entitled "The Use of Money" (1770) where in a certain way he pointed out the key elements of social investing i.e. not to harm your neighbour through your business practices and to avoid industries like tanning and chemical production, which can harm the health of workers.

The modern history of Ethical Investment started in the 1980's. From then and into the early '90s a handful of ethical funds emerged, forming what essentially was a cottage industry. One of them, the North Coast Ethical Credit Union Limited, was started in the Northern Rivers in 1990. Headquartered in the Lismore LGA, it was absorbed into Summerland Credit Union three years later. The latter entity has flourished and is an extensive supporter of local community endeavours.

One of the earliest funds emerged from the Earthbank Society which itself grew out of Permaculture. Almost all have since disappeared, except Australian Ethical. At that time the terminology chosen was Ethical Investment; this was more in keeping with UK nomenclature in contrast to America where Socially Responsible Investment (SRI) was typical.

By the early 2000s big conventional fund managers and financial institutions like BT, Colonial, Westpac and AMP showed interest in the sector. More marketing spin than anything, new products were often labeled Socially Responsible, Sustainable, Green, Eco or Environmental.

The ways monies can be invested to achieve what the consumer wants from an ethical or sustainable point of view can be done 5 ways as detailed below:-

- Negative screening – Avoiding companies and industry sectors that cause unnecessary harm to people, planet and animals (e.g. gambling, weapons, fossil fuels)

- Positive screening – Seeking out companies and sectors that are progressing society (e.g. education, technology, healthcare)

- Sustainability themed investing – Focusing on assets that enable sustainable solutions (e.g. clean energy, forestry, sustainable water supply)

- Impact or Community investing – Providing finance to businesses with a clear social purpose, or providing capital to supply goods and services to underserved communities

- Corporate engagement – Influencing corporate behaviour through direct engagement with senior management and/or boards

According to the Responsible Investment Association of Australia (RIAA) their members which include all the major Ethical Investment companies and funds (incl Superannuation), hold over $9 trillion in assets. According to their data the returns for Ethical Investment are generally higher than the mainstream market. So perhaps one can have one's cake and eat it too (RSPCA approved!)

Dr Nathan Kestevan is a local GP and Board chair of Northern Rivers Doctors

UN Principles for Responsible Investment

The **principles for responsible investment** (PRI) were launched in 2006 after an initiative by Koffi Annan.

The 6 PRI are the following:

1. We will incorporate environmental, social and corporate governance (ESG) issues into investment analysis and decision-making processes. Signatories can follow the first principle by supporting the development of ESG-related tools, metrics and analyses and by encouraging research and analysis by service providers and academics on ESG-related issues.

2. We will be active owners and incorporate ESG issues into our ownership policies and practices. Signatories can follow the second principle by promoting and protecting shareholder rights and by engaging with companies on ESG issues.

3. We will seek appropriate disclosure on ESG issues by the entities in which we invest. Organizations can ask companies to integrate ESG components into their annual financial reports and request standardized reporting of ESG issues through tools such as the Global Reporting Initiative (GRI). The GRI is a sustainability reporting effort that asks organizations to disclose their impact on issues such as climate change, human rights, and corruption.

4. We will promote acceptance and implementation of the principles within the investment industry. Signatories can communicate their ESG expectations to service providers and revisit relationships with providers that do not adhere to ESG guidelines.

5. We will work together to enhance our effectiveness in implementing the principles. Organizations can collaborate to address new issues and support initiatives by sharing information, tools and resources.

6. We will each report on our activities and progress towards implementing the principles. Through this principle, organizations can raise awareness of ESG principles among stakeholders and beneficiaries.

COVID-19 - Big foundations to the rescue?

by Robin Osborne

In the week that WA miner Andrew 'Twiggy' Forrest's Minderoo Foundation purchased 10 million COVID-19 test kits from China (to be handed out to hospitals, clinics and labs around Australia), an acquisition of a related but different kind was announced by another businessman with apparently deep pockets, Clive Frederick Palmer (to use his Facebook handle).

A Clive Palmer 2019 federal election billboard near Alstonville attracted some creative retouching.

In the unlikely event that Australia faces a malaria epidemic, 32,900,000 doses of hydroxychloroquine may come in very handy. However, the value of this drug to treat COVID-19 patients is less than certain, let alone being a 'miracle cure', and could be positively dangerous, according to some medical authorities. For instance, heart problems are one of the drug's known side-effects.

While US President Trump "What have you go to lose?", his country's FDA warned against its use outside a hospital or trial.

Undeterred, Mr Palmer announced his extraordinary purchase in a series of **full-page ads in the metro press**, printed in the bright yellow that has become one of his trademarks. Readers may remember his yellow-themed publicity campaign during the last federal election.

Observing Oscar Wilde's maxim that nothing succeeds like excess (although he and his party failed to win a parliamentary seat) Palmer bought three full-pages in The Sydney Morning Herald of 2 May 2020 to trumpet his hydroxychloroquine purchase – "The Palmer Foundation has donated the drug to the Australian Government to be placed on the National Medical Stockpile…"

The first ad, in the form of a message from Palmer, went on, "I am happy the quick action we took in early March to secure hydroxychloroquine for Australia has been successful… If we had not moved when we did, we would have lost our opportunity."

So far the government has not rushed to thank him for his generosity, while the drug in question remains on hold as a treatment for coronavirus.

The following double-page ad spread, ending with a grinning photo of The Palmer Foundation's boss, presents a complicated chronology of the COVID-19 pandemic and a spiel about how hydroxychloroquine, a drug synthesized in 1946 and approved by the FDA in 1955, is "showing enormous promise in the treatment of COVID-19", beyond its usage in treating lupus, rheumatoid arthritis and malaria.

The words "we are living in unusual times" have often been voiced during the COVID-19 pandemic, and a perfect example has been the way businessmen with mining backgrounds have sought to assist the national response. One of them managed a deal with a country that is thought to have enabled the spread of the disease in the first place, while the other has helped stockpile a drug that may or may or may not help counter it, and anyway does not seem to have been in critically short supply.

Strange times indeed.

To Hydroxychloroquine, or not?

The 22 May 2020 edition of The Lancet published a large multinational study on the use of hydroxychloroquine or chloroquine with or without a macrolide in the treatment of in-hospital Covid-19.

It had been hypothesized that these drugs had not only anti-inflammatory effects, as seen with their use in autoimmune diseases such as systemic lupus erythematosus and rheumatoid arthritis, but also had antiviral properties

The study collected data from 671 hospitals located across 6 continents. 96,032 hospitalized patients were recruited and were randomised to a control group (81,144) and four treatment groups given chloroquine or hydroxychloroquine with and without macrolides.

The study revealed an increased risk of in-hospital death and ventricular arrhythmia in the treatment groups.

The drug had been promoted by President Donald Trump as well as Australian entrepreneur, Clive Palmer. On 19 May Trump said, "I get a lot of tremendously positive news on the hydroxy, and, you know, I say, hey… what do you have to lose?"

While the quest for an effective treatment for Covid-19 continues, it is foolish to promote any treatment that does not have scientific validity. This study provides a salutary lesson to politicians as well as to the public they serve.

On 26 May **the WHO announced** it would temporarily drop hydroxychloroquine from its global study into experimental coronavirus treatments after safety concerns.

Brewers whoop over delay to drink pregnancy warnings

Food Standards given three months to develop more "common sense" labelling

Were the consequences not so serious the decision to go back to the drawing board on warning labels about the risks of consuming alcohol in pregnancy would be laughable.

Now, after the recent meeting of the Australia and New Zealand Ministerial Forum on Food Regulation it is the alcohol lobby that is doing the laughing, announcing in a triumphal media release that, "Common sense has prevailed over the bureaucratic frolic that had been Food Standards Australia and New Zealand's (FSANZ's) draft recommendations on pregnancy warning labels on all alcohol products."

The reference was to the Forum's rejection of a clear bottle label warning of the dangers of drinking during pregnancy.

Similar words were used in a media release by an Australian representative on the group, Nationals MP and Minister for Agriculture, Drought and Emergency Management, David Littleproud, who said, "We need to implement this in a common sense way that understands the realities of branding and label manufacturing."

Put simply, the draft label released by FSANZ in late 2019 was, according to its opponents, too expensive for manufacturers to print and affix. Supporters said it was seen as too explicit and likely to do the job too well. The graphic showed a silhouette of a pregnant woman and the message, "Health warning: Any amount of alcohol can harm your baby". The warning colour red was a part of the design.

Upon its release the design sparked a new attack by the alcohol industry, which pursued a lobbying campaign aimed at generating political opposition to a label that was bigger, more readily understood and more "colourful" than the existing pregnancy warning on all beer, wine and spirits sold in Australia.

The current design, nearly invisible, is positioned beside other product information – alcohol content, manufacturer's address etc – on bottle labels. It makes no mention of pregnancy, showing only a tiny silhouette of a person who may just be a pregnant woman. It has a minute reference to the website of DrinkWise, a body established in 2005 by… the alcohol industry.

The debate is not new – last year Alcohol Beverages Australia chief Andrew Wilsmore said that while customers "have the right to know what they're drinking and what's in it" putting "too much information" on a warning label risked confusion… "You get this thing called label haze, where nothing gets taken in at all."

After the postponement decision, the Brewers Association of Australia, claiming to speak on behalf of Australia's 9.1 million beer drinkers (who "Can't be wrong") said, FSANZ's bid to mandate colours – specifically red, white and black – "ignores all practical measures to sensibly shift to mandatory labelling and has sought to impose the largest possible cost option on consumers…

"Food Forum Ministers today brought the bureaucrats back to reality by rejecting their draft recommendations and instructing FSANZ to go back to the drawing board."

Clearly the current labelling hasn't resonated with pregnant women, even those with keen eyesight: studies in NSW and Victoria show that 59 per cent of women reported alcohol use in pregnancy, often at risky levels before they were aware they were pregnant.

An AIHW study on household drug use found that 49 per cent of women drank before they knew they were pregnant and one-in-four continued to drink thereafter.

The serious health risks of drinking during pregnancy have been well known for years. They include foetal alcohol spectrum disorder, children struggling with learning, behaviour and development, physical disability and intellectual impairment, all caused by a brain injury caused by prenatal exposure to alcohol.

The Forum, along with Minister Littleproud ("No-one is arguing that mandatory pregnancy warning labelling should not happen") and even to an extent the alcohol industry acknowledge that drinking and pregnancy are a toxic mix. The debate is over how clearly this should be communicated to the public.

To the maximum, according to FSANZ and the Foundation for Alcohol Research & Education (FARE), whose CEO Caterina Giorgi said the "backtrack" by government was due to "relentless pressure" from the alcohol industry that aimed "to keep the community in the dark about the health harms from alcohol use during pregnancy… At the heart of this is the health and wellbeing of our children and communities.

"We will continue to advocate for a pregnancy warning label that is clear, visible and trusted, which will give future generations the best start in life."

While the industry may be content with the current minimal labelling, it appears to accept that pressure is mounting for an upgraded warning and that doing nothing - apart from continuing its lobbying - is no longer an option.

Time will tell and at this stage there does appear to be a great deal more of it.

Minister Littleproud believes "It's important that we don't kick this can [or bottle?] down the road. That is why we've asked FSANZ to conduct a review of the wording and colour of the proposed warning labels within three months."

So it's literally back to the drawing board in a saga not far removed from the acrimonious fight over cigarette warnings before the packaging gained community acceptance and began making a positive contribution to Australians' health.

Students take AIM at enhancing clinical skills

In April, University of Wollongong (UOW) final year medical students joined their peers from the University of Sydney and Western Sydney University in a clinical skills training day at the University Centre for Rural Health's Lismore campus. This was part of a week of training to prepare them for the Assistant in Medicine (AIM) program. Another ten UOW final year medical students, placed at UCRH's Murwillumbah Hub, undertook similar training.

The AIM Program is a Department of Health initiative designed as a bridging program to fast track final year medical students into the medical workforce in preparation for the potential COVID-19 surge. The number of AIM positions available is yet to be determined and will be dependent on clinical need.

The Lismore day included a tutorial program covering practical processes such as handover and referral notes, completing discharge summaries, death certificates; interpretation of ABGs and ECGs as well as a session on breaking bad news. Students also rotated through practical skills stations including hand hygiene, appropriate use of personal protective equipment (PPE), IV cannulation, urinary catheterisation, basic life support, and suturing. These skills were delivered by a number of clinicians from the Northern NSW LHD, including Surgeons, Emergency Physicians and GPs.

The focus in Murwillumbah was similar, aiming to reinforce skills that the students had been developing during their course and providing an opportunity to practice skills or situations they may encounter as new practitioners in their AIM role. The day was also a mixture of tutorials and simulated practice, somewhat restricted because of social distancing requirements during the pandemic. We combined practice in handwashing and appropriate use of personal protective equipment (PPE) to be able to safely run Advanced Life Support (ALS) scenarios in which the students participated enthusiastically. Other skills and tutorials covered included ECG interpretation, arterial blood gases, urinary catheterisation, intravenous fluid administration, intravenous and intramuscular injections. There was special mention of the excellent sessions presented by Dr Marc Heyning and Dr David Engel.

The written and verbal feedback from the students at both training days was overwhelmingly positive. They said sessions were well presented and valuable in enabling them to improve their clinical expertise. The students also liked how we concentrated on things they have not had as much practice in their placement or during previous workshops/tutorials.

Facilitating such an event and respecting social distancing protocols during a pandemic presented a unique challenge, however by restricting group sizes and rotating students through small workshops this was achieved. Students commented that they felt more prepared and informed following the program.

The day would not have been possible without the support of the Lismore Regional Training Hub and the Local Health District who collaborated with the UCRH in the provision of resources and support. Thanks to the UCRH team for their hard work in developing and facilitating the workshop.

With the 'flattening of the curve', the availability of AIM positions may be less than originally thought when these sessions were planned. We wish all our students the best of luck in obtaining an AIM positions if/when they are required. Otherwise the workshop will be a valuable day spent honing their skills for when they complete their final requirements to become Interns next year.

UNIVERSITY OF WOLLONGONG AUSTRALIA

IS ISOLATION AND ITS CHALLENGES IMPACTING YOUR PATIENTS' MENTAL HEALTH?

LET US HELP YOU

Currumbin Clinic offers a discrete environment with exceptional evidence based care to support people experiencing increased anxiety, psychological distress and/or addiction issues due to COVID-19 impacts like social isolation and interruption to normal daily routines, employment or study.

In response to the current crisis we are continuing to accept referrals for inpatient treatment or can offer new telepsychiatry options so people can continue to access important mental health support from the safety and security of their own home.

Bulk billing options may apply for eligible persons via Medicare rebates.

Regarded as the centre for excellence on the Gold Coast for mental health and addictive disorders that often go hand-in-hand, Currumbin Clinic is a 104 bed private mental health facility delivering exceptional care and positive patient outcomes.

MENTAL HEALTH AND ADDICTIONS

Admissions and Assessment

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Currumbin Clinic

37 Bilinga Street, Currumbin QLD 4223
T: 07 5534 4944 F: 07 5534 7752
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Luye Medical

Virus naming can send us batty

By Mike Fitzgerald,

Veterinary Surgeon, Alstonville

Photo by Kristin den Exter, Friends of Rotary Park, Secretary, Wilsons River Landcare Group Inc. **www.facebook.com/wilsonsriverlandcare** Follow on Twitter @WilsonsRiver

When I studied virology as a vet student decades ago, it was accepted as a general rule that each species of virus was uniquely adapted to a single host species. Dogs didn't get cat viruses and vice versa. You can't get the cat-flu from your cat or give your flu to your dog etc.

Ferrets are a somewhat random exception: they have similar respiratory physiology, and the same sialic acid receptors that human Influenza viruses latch on to. So, you can get Influenza virus from your ferret, as well as passing it on to your ferret, and they provide a critically important animal model for studying influenza and other human viruses.

However, I digress…

The exception to this general rule, a species-jump or spill-over resulting in a novel viral zoonosis, has certainly made life more complicated of late. Whilst some of the recent zoonotic viral epidemics and pandemics have originated in monkeys (HIV from Simian IV), birds (H5N1 and others) and pigs, in the last two decades three large-scale disease outbreaks, including the current SARS-CoV-2, are coronaviruses that originated in bats. others are SARS in 2003, MERS in 2012, and SADS (Swine Acute Diarrhea Syndrome). Two of those three outbreaks began in China.

Then there are a few other bat-borne or bat-origin zoonotic viruses: Ebola, Nipah, Hendra and Lyssavirus.

Ever wondered… why bats and, why China?

Firstly, there are a lots of bats. Of all of the world's mammalian species, 20 per cent are bats. They cover nearly all habitats across six continents. They mostly live in cosy, dense colonies numbering hundreds to thousands of individuals. Plus, they can fly and migrate hundreds of kilometres, which means rapid dispersal of not only the seeds and pollen of important tree species but also dispersal of viruses.

Bats harbour a higher proportion of zoonotic viruses than other mammalian species, and most of the virus families can be found in bats. In 2013 bats were known reservoirs of more than 60 viruses that can infect humans, including coronaviruses, poxviruses, paramyxoviruses, orbivirus and more.

Direct contact between humans and bat secretions, urine or faeces can occur in caves, tunnels, mines and buildings. In some parts of Asia and southern China, bats are used as food and in traditional Chinese medicine, with dried guano used as fertiliser. All these things increase the chance of virus transmission.

Although novel bat viruses with zoonotic potential are being discovered worldwide, China definitely seems to be a hot spot. There are logical reasons for this: it is the third largest country in the world, with the largest population, a diverse climate and great biodiversity, which includes bats and bat-borne viruses.

In a paper submitted in January 2019 researchers, who included China's Zheng-Li Shi (the virologist dubbed 'China's Bat Woman' - https://www.scientificamerican.com/article/how-chinas-bat-woman-hunted-down-viruses-from-sars-to-the-new-coronavirus1/) predicted an outbreak of a novel zoonotic coronavirus of bat origin most likely in Yunnan province, given the results of extensive survey work.

In 2013, they discovered a SARS-related bat coronavirus, which crucially used the human ACE2 entry receptor, which SARS-CoV-1 and 2 (Covid19) both exhibit. They were pretty spot on, except that SARS-CoV-2 appeared in Hubei not Yunnan.

Which brings me to the naming conventions for new disease-causing viruses. Wuhan, the city in Hubei province where the first cases were recognised, got off pretty lightly with SARS- CoV-2, formerly known as Covid19. The International Committee on the Taxonomy of Viruses followed new 2015 WHO guidelines which state best-practice was to avoid the use of geographic, personal, occupational names which might lead to stigmatisation.

This will no doubt provide cold comfort to the burghers of Hendra, Messrs Creutzfeldt and Jakob, many French Foreign Legionnaires and the former proprietors of Ebola River Scenic Cruises.

Meanwhile, closer to home, in my beloved home village of Alstonville (Tidy Towns Finalist 1985), researchers from CSIRO's Animal Health Laboratory in 2018 isolated a novel Paramyxovirus that can induce upper respiratory tract infection in ferrets, from bat urine collected from flying foxes in Alstonville: Alston Virus (AlsPV). It is closely related to Simian Virus 5 and may have a similar ability to infect multiple mammalian species.

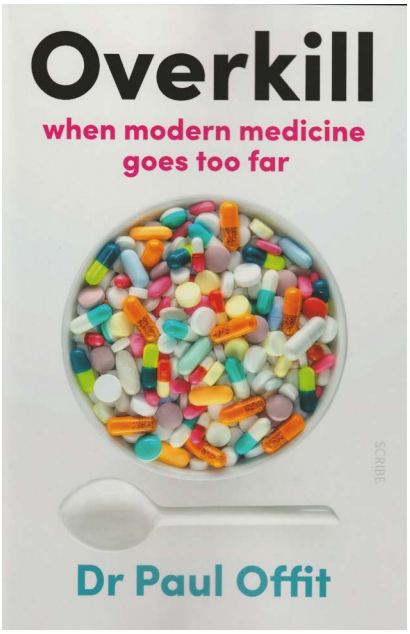
Yay, we're famous!

Book Review

Overkill

Dr Paul Offit

Scribe 288pp



by Robin Osborne

With ample end notes (50 pages worth) to support challenges he may expect to be forthcoming, this hit-list of medical myths and misguided therapies comes from a highly reputable source - the director of Vaccine Education at the Children's Hospital in Philadelphia and a professor of vaccinology and paediatrics. He is also the author of ten previous works.

From both a clinician's and a consumer's perspective, Dr Offit's narrative is disturbing one, indicating a massive waste of money on ineffective treatments and the delivery of false hope to patients who continue to believe in the "miracles" of modern medicine, or perhaps just canny advertising.

The chapter headings give a taste of what's to come: "Finishing the Antibiotic Course Is Often Unnecessary", "Vitamin D Supplements Aren't a Cure-all", "Baby [i.e. low-dose] Aspirin Doesn't Prevent First Strokes or First Heart Attacks", and "Prostate Cancer Screening Programs Do More Harm than Good".

Dr Offit kicks off with a counter narrative, a therapy that does work but was long ignored. In 1747, prompted by the devastating impact of scurvy on Britain's sailors, a young Scottish surgeon named James Lind conducted what many now consider to be the first clinical study. He split twelve sailors into six groups of two men, offering each group a different 'remedy': bad luck for those who had to ingest 25 drops of sulphuric acid thrice daily, much better for those consuming two lemons and an orange.

Lind's results were not published for six years, and even then no one heeded his findings, despite a further 18,500 British sailors dying from scurvy, more than were killed in battle, as the author notes.

Why was his milestone work ignored?

"Surely, when confronted with clear,

unambiguous evidence that a treatment works or doesn't work, we embrace the findings," Dr Offit writes.

"In the pages that follow, I will describe situations in which clinicians have ignored a wealth of evidence and continued to prescribe medicines, or perform surgeries, or promote cancer screening programs, that have been shown to do more harm than good."

Delivered a hammer blow are the notion of attempting to treat fever, supplemental antioxidants, the prescribing of testosterone, avoiding allergenic food for infants, prostate, thyroid and to an extent breast cancer screenings, heart stents and surgery (and acupuncture) for knee arthritis.

Finally, he circles back to vitamin C, with a chapter explaining how research shows it neither treats nor prevent colds, despite its glowing endorsement last century by Nobel Prize winner Linus Pauling who at one point was taking 18,000 mg per day - all for nothing as it turned out - and massive sales to this day.

The rhinovirus (literally, "nose virus") is "easy to spread... primarily by sneezing, coughing, or even talking... also by shaking hands or by touching a doorknob or an ATM machine or any other surface that an infected person recently touched."

Noting that infinite remedies have been tried against the common cold, including cough suppressants, pain and fever medicines, eucalyptus oil and echinacea, Dr Offit notes, "As a general rule, when so many different medicines are claimed to work, none of them probably does."

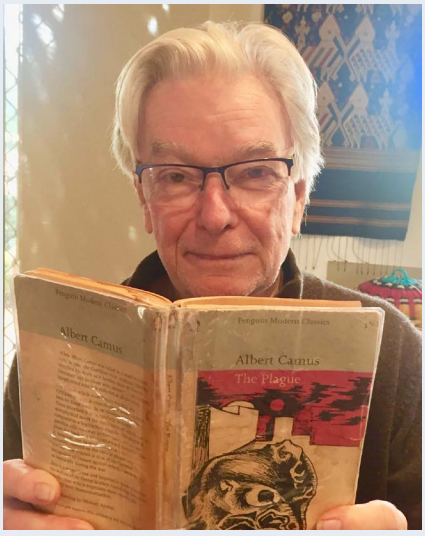
In fact, the most effective remedy has been found to be heat: "Rhinoviruses survive better at the colder temperatures found in the nose... than at core body temperatures... as it turns out, after all these years, a treatment for the common cold that offers some benefit has been right under our nose."

If only treating COVID-19 was as simple as a steaming inhalation.

Reading The Plague during the pandemic

GP Speak's Robin Osborne with the Richmond Tweed Regional Library's sole copy of Albert Camus' The Plague.

Thanks to Covid-19, copies of The Plague are unobtainable on the internet, new or used, so I turned to our local library... one copy in stock and the advice was, "We know it's battered, so don't worry, we've taken note."



Published in 1947, the classic novel by existentialist author Albert Camus (1913-1960) is set in Oran, in then-French controlled Algeria, and has many uncanny similarities with the progress and impacts of the coronavirus pandemic. Some say it was a metaphor for the Nazi occupation of France - Camus fought with the Resistance - but let's stay with the viral parallels.

This could be the Donald Trump-fuelled protesters outside Democratic state legislatures: "The prisoners of plague put up what fight they could. Some... even contrived to fancy they were still behaving as free men and had the power of choice."

The onset of the plague that would decimate Oran was heralded by the appearance of dying rats, and before long the citizens would be following in their wake: "The authorities were accused of slackness, and people who had houses on the coast spoke of moving there."

Sound familiar?

How about the comparisons with wartime?

"There have been as many plagues as wars in history; yet always plagues and wars take people equally by surprise," Camus writes in words attributed to the central character, Dr Rieux.

Then we have the dire warnings: "It may well, unless we can stop it, kill off half the town before two months are out," hence the need for urgent measures.

"The townspeople were advised to practise extreme cleanliness... and ordered to promptly report any fever case diagnosed by their doctors and to permit the isolation of sick members of their families in special wards at the hospital."

Finally, after much debate about terminology, a telegram comes from the authorities: "Proclaim a state of plague Stop Close the town".

A new phase of the epidemic begins when announcements of the death count move from weekly to daily, while another familiar message is "The best protection against infection is a bottle of good wine."

Restaurants post notices saying, "Certified that our plates, knives, and forms are sterilised," while "the most striking feature of our funerals was their speed. Formalities had been whittled down, and, generally, speaking, all elaborate ceremonial suppressed. The plague victim died away from his family and the customary vigil beside the dead body was forbidden, with the result that a person dying in the evening spent the night alone... the family was notified but... in most cases its members were in quarantine and thus immobilised."

Such measures were seen to have effect: "The graph after its long rising curve had flattened out," a trend attributed to a "new serum which, indeed, had brought off some quite unlooked-for recoveries", at which time "the epidemic was in retreat all along the line", heralding the opening of the city's gates and what one character calls "a return to normal life."

When asked what that meant, he replies, "New films at the picture-houses."

It also meant closing quarantine camps, opening restaurants and staging celebratory street parades. For Camus, the novel would count towards his Nobel Prize for Literature although he never would have expected to be writing a script for a plague in the 21st century.

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Dr Sarah McGahan MBBS FRCPA
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Dr Sarah McGahan is Pathologist-in-Charge of SNP's Lismore laboratory. A graduate of The University of Queensland, she trained in pathology at Royal Prince Alfred Hospital, Sydney. In 1995 she moved to northern NSW, where she worked at Lismore Base Hospital for 13 years, joining SNP in 2008. She has expertise in a broad range of histopathology including dermatopathology and gastrointestinal pathology, and has a particular interest in melanoma.

Dr Andrew Mayer MBBS(Hons) FRCPA
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Dr Andrew Mayer has expertise across a broad range of general surgical pathology with particular interests in breast, gastrointestinal and dermatopathology. He graduated with honours from the University of Sydney in 1989 and went on to one year of forensic pathology training at the NSW Institute of Forensic Medicine, followed by five years in anatomical pathology training at the Institute of Clinical Pathology and Medical Research (ICPMR), Westmead Hospital.

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Dr Patrick van der Hoeven is a general pathologist with extensive experience in surgical, breast and gastrointestinal pathology and dermatopathology. He graduated in Medicine from Queens University, Canada and gained his Fellowship of the Royal College of Physicians and Surgeons of Canada in 1994. He moved to Australia soon after and worked for Gippsland Pathology Service in Victoria where he became Deputy Director of Pathology and a partner. He joined Sullivan Nicolaides Pathology in 2019.

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Meridio 322441 September 2019

Local GP sees cannabis as a "tool in the treatment box"

"Standardised cannabis products can and are being prescribed in Australia," notes local GP David Gunn, who has left a larger practice to set up on his own to focus on areas of medicine he's passionate about – difficult to treat problems such as mental health, chronic pain, insomnia, addictions and musculoskeletal injuries.

Cannabis-derived formulations may have an important role in alleviating such conditions, Dr Gunn believes, and he supports further clinical investigations of their value.

"Patients are already using cannabis as a medicine and are demanding access to it. I believe that when done carefully, for the right patients, doctors can safely prescribe these medications and that it is reasonable, conscionable and compassionate to guide them in these circumstances."

Stressing that he is a "doctor, not a cannabis doctor", Dr Gunn added, "The majority of patients who see me won't be seeing me for cannabinoids. The people I'm hoping to see are stuck with a problem and I want to see if by spending a bit more time with them and connecting them with the right people, maybe we can move some of those stuck problems.

> "Prescribing cannabinoids is simply one tool in my tool box, that's how I see it."

The first 12 years of Dr Gunn's career were spent in a small hospital in Nova Scotia, Canada where in addition to his GP duties he worked in emergency medicine, inpatient care, nursing home care, palliative care and opioid replacement medicine.

David and a colleague completed opioid replacement training and started a clinic for patients dealing with opioid addiction. Throughout this time cannabis was available for use in Canada.

"At first it was not available as we prescribe it now. In the beginning, it was a piece of paper that said 'You may possess cannabis flowers to use for a particular condition'. Back then patients would come into me and say 'Doc, I know this helps with my arthritis, would you consider prescribing it?' Purely from a harm minimisation perspective, in some cases I was comfortable with it.

"Along the way I just kept talking to my patients about cannabis. I was not seeing disasters, I was not seeing horrible things happening to people as a result of cannabis. I'm not saying that cannabis use doesn't have harms, it does. Any drug can, but it was time for me to start looking at it as a good option for chronic pain and over the years I integrated it into my daily practice."

Over the past decade a medicinal cannabis industry has evolved and after David and his family came to the Northern Rivers three and a half years ago he started to reassess his working life as a GP.

"Prescribing cannabinoids is very different here, it took me a while to understand what's possible and what's reasonable. My practice has been focused on chronic pain and mental health for some time and I generally find prescribing cannabinoids very rewarding. It is nice to see a patient do well on a medication that they actually want to take."

David resumed prescribing cannabinoids here in Australia two years ago, becoming an authorised prescriber of medicinal cannabis and buprenorphine, and an advocate for Harm Reduction Australia. He has been active in delivering educational talks to physicians on the use of cannabis as an unregistered medication for the treatment of chronic pain.

He also linked up with Emerald Clinics and has been seeing patients locally using their model of care since last October.

"I like their model which includes longer consultations and generating evidence around the use of medicinal cannabis while giving quality care. It's really a pleasure to work this way. And right now the biggest criticism against using cannabinoids is that there isn't the same level of evidence as there is for other medications which is one of the reasons it remains an unregistered medication."

"It's fair enough, cannabis doesn't have that level of evidence yet, and that's why it's being used as a treatment when all else fails. But there are reasons why the evidence isn't there. It's been illegal for a long time. I think it is reasonable that doctors who are knowledgeable in prescribing it can guide patients who want to use it when other things haven't worked. And while we're doing it, why don't we prove that it's helping them and not just a placebo effect?

"Personally, I have seen too many people's lives improved to be convinced otherwise, but I accept that doesn't cut it as far as evidence goes, so let's find out what works and what doesn't."

He's keen for GPs to refer patients with hard to treat problems, but the area of medicine he is most experienced in treating with cannabinoids is chronic pain. He says that particularly for chronic neuropathic pain, combinations of CBD and THC can work quite well.

He adds that it is possible to use THC, the psychoactive form of cannabis, as a medicine without the mood altering effects.

"If a patient with chronic pain has tried standard management and they've worked through those things, then I approach their case from a 'first, do no harm' point of view. How much harm are we going to introduce into these patients' lives with a careful trial of cannabis? Typically the answer is not very much if it's done properly."

Other conditions he is keen to treat are insomnia, inflammatory bowel disease, cancer-related care (nausea and vomiting and loss of appetite), spinal injuries and spasticity - in conditions like multiple sclerosis and cerebral palsy.

He's also had some success in treating PTSD with medicinal cannabis, but says he takes a cautious approach and involves a mental health team.

"When I do prescribe cannabinoids, I mostly prescribe oils which are consumed orally, these products are TGA approved and patients fill their prescriptions through their usual pharmacy. Most of the pharmacies in the area are now quite comfortable dispensing cannabinoids.

Dr David Gunn will be practising at: Emerald Clinics 22 Rous Road Goonellabah and 65 Main Street Alstonville (both in RightFoot Podiatry Building). For appointment information and Online Booking: **www.maritimehealthclinic.com.au and www.emeraldclinics.com.au**

National Phone Number:1300 436 363

GPs can refer to Dr David Gunn via Fax Number for Emerald Clinics: 08 6559 2829

Book Review

by ROBIN OSBORNE

See what you made me do

By Jess Hill

Black Inc 402pp

With apologies for the crudeness, one comes to this book, sub-titled 'Power, Control and Domestic Abuse', as if picking up a plastic bag of dog turds discarded by an irresponsible walker. Take a deep breath, fasten your seat belt, this will be an uncomfortable ride.

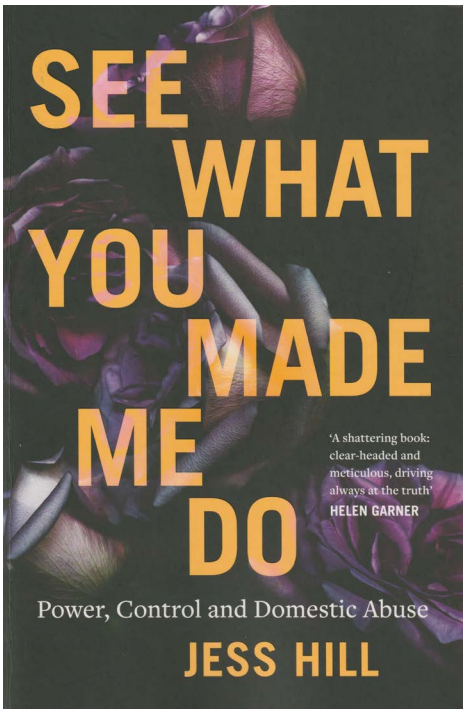
The subject matter is so unpleasant and the case histories so harrowing that the reader is likely to recoil with a mix of horror and disbelief: how can people treat others, mostly women and in all likelihood partners, so dreadfully; how can so much of society, not least family members, turn a blind eye; and how can authorities be so unsupportive of those suffering the injustices of this all-too-common abuse?

That said, extracts from police logs of domestic violence call-outs show the magnitude and intensity of the problem, and the challenges of officers to face some dire circumstances, while concerned relatives often feel powerless to intervene.

In seeking to answer these challenging questions Jess Hill has delivered a highly intelligent book that was four years in the research and writing, and which won this year's Stella Prize for women's literature. Widely acclaimed, and with considerable publicity, it has helped focus the spotlight on the ghastly yet hidden crimes occurring in households throughout Australia.

Despite this, the rates of domestic abuse have risen during the COVID-19 lockdown, with partners (and children, plus household pets) reporting greater suffering because of enforced proximity to their abusers, many of whom have become less employed and as a result even more frustrated and aggressive.

In her first chapter, The Perpetrator's Handbook, Hill compares the compliant behaviour of domestic abuse victims with American POWs in North Korean camps during the Korean war, writing, "Speak to anyone who's worked with survivors or perpetrators and they'll



tell you the same thing: domestic abuse almost always follows the same script. It's a truly confounding phenomenon: how it is that men from vastly different cultures know to use the same basic techniques of oppression?"

Some commentators – you know who you are, Pauline Hanson, Bettina Arndt, Andrew Bolt et al – have sought to position this book within the context of radical feminism, unfair targeting of men, and so on, but the facts speak for themselves... "It... is... inarguable... when people kill their intimate partners, they are almost always killing a perpetrator... There is nothing comparable about male and female victims of domestic homicide in heterosexual relationships. When women commit intimate partner homicide against men, they almost always do it after suffering years of abuse.

"In the vast majority of cases, women kill because they can think of no other way to be safe."

How do women rationalise their abuse? One study found there are six ways, and the titles are self-explanatory: 'I can fix him', 'It's not really him', 'It's easier to try to forget', 'It's partly my fault', 'There's nowhere to go', and 'Until death do us part'.

Hill says some women can spend their entire lives rationalising the abuse they suffer, adding that they may distract themselves from their "unbearable reality" through substance misuse, eating disorders, gambling and so on..."Cruelly, this will likely render them untrustworthy to friends, family and the courts if they do try to leave."

It is challenging to do justice to a complex book about a very difficult - although stripped down, a remarkably simple - subject: control over, and the abuse of, other people, not least partners. Such behaviour is totally unacceptable - What part of NO! don't you understand?

As Jess Hill writes, "For those who don't believe it's possible to reduce domestic abuse now, consider this: five years ago, few could have imagined something like #MeToo: a revolution not just against sexual harassment, but against patriarchy itself... Revolutions are impossible, until they are inevitable."

This discomfiting study will be embraced by those inclined to accept its analysis but, unfortunately, may miss the mark with those yet to come to grips with their behaviour.

Lismore's High Risk Foot Service improving patient outcomes

There is a large variation of clinical outcomes across regional NSW for High Risk Foot Service (HRFS) patients, with evidence that a specialist outpatient service can improve outcomes. Decreasing the risk of lower extremity amputations, hospital admissions and the associated loss of productivity, morbidity and mortality can reduce associated hospital expenditures by up to 85%[1].

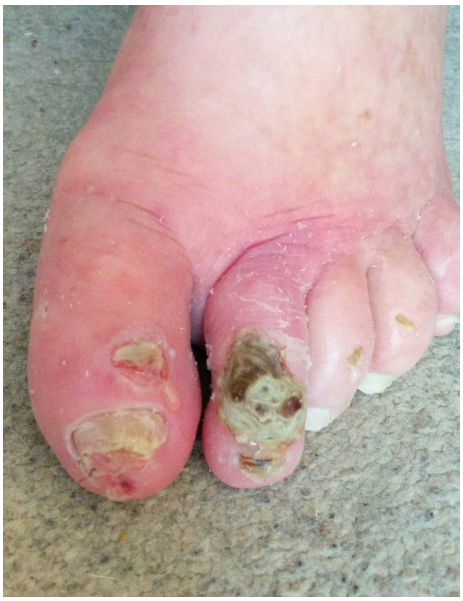
The Agency for Clinical Innovation (ACI) Endocrine Network has identified the importance of standardising services across the State to reduce the variation in outcomes and ensure appropriate access for patients with diabetes related foot complications. Recognising that resources vary based on what is locally available, Lismore Base Hospital's HRFS has developed a multidisciplinary service in the Richmond Valley to provide a level of care beyond that delivered by traditional podiatry.

This area has some of the highest rates of hospitalisation in NSW for diabetic foot disease, a significant number of which are found to be avoidable[2]. This is at least partially due to Lismore Base Hospital being the tertiary referral service for both the Richmond and Clarence Valleys. Irrespective of the reason for the high rates of admission, there is a recognised need for an outpatient HRFS and escalation pathway, and for follow up for these at risk patients.

In recognising that lower limb complications contribute to unnecessary hospital admissions and amputations, the State based Leading Better Value Care (LBVC) initiative has demonstrated that specialist outpatient HRFS can improve medical outcomes. The spectrum of diabetic foot disease complications includes ulceration, deformity, ischemia, infection (including osteomyelitis), and Charcot's neuroarthropathy.

There is a large body of evidence to support the fact that the majority of diabetic foot ulcers can be healed under the guidance of a multidisciplinary team, with only a few requiring a lesser (below the ankle, often digital) amputation.

The demographic of the Richmond Valley is an ageing population and the



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North Coast Primary Health Network has identified that the availability of podiatry services in the Lismore area is below the nationally recommended level.. Additionally, there are large pockets of disadvantage, a lower than average level of education and many other socioeconomic determinants of health that contribute to poorer outcomes for this population, and these have contributed to a higher than State average rate of diabetes diagnosis, complications and hospital admissions.

The podiatrist for the HRFS commenced work in February 2019, and was initially involved in a planning role, modelling the service on the National Association for Diabetes Centres [NADC] and ACI Guidelines and Key recommendations for High Risk Foot Services[3].

Since its inception, the HRFS has been able to meet a majority of the key recommendations and standards. The service operates in line with best practice guidelines and national and international models of care. The clinical lead podiatrist manages the clinical load, oversees the broad spectrum of care and endeavours to action referrals within one day of receipt. Prioritisation criteria determine the allocation of urgent appointments.

Recommendations from both the NADC and the ACI state that structured multidisciplinary clinics should be held in both the morning and afternoon to ensure patient access, and that there should be access to medical oversight with escalation to subspecialist involvement in the clinic at least once every two weeks. The HRFS has effectively been able to meet this recommendation as it is located on site at Lismore Base Hospital, where it holds its four specialist clinics each month.

The HRFS has access to the vascular teams, including consultants Dr Dominic Simring, Dr Anthony Leslie and Dr Deepak Williams, and to their teams for escalation as required.

Input can also be sought from other specialties where appropriate. These include but are not limited to Infectious Diseases (Dr Sarah Coghlan), Renal and Endocrinology/General Medicine. These services are accessed typically by phone as required but when physical review is necessary this is coordinated through the Lismore Base Hospital Emergency Department.

For those requiring corrective surgery or an orthopaedic opinion, an outpatient clinic is run once a month by Dr Richard Freihaut and the LBH orthopaedics team provide specialist input outside of the clinic's hours.

The allied health MDT clinics are once a week in the morning and once a month in the afternoon.

There has been overwhelming positive feedback from those involved in assisting the service. Prior to the commencement of the LBH HRFS there was a clear gap for patients in the Richmond Valley. The service now meets almost all the criteria set out in the national NADC HRFS standards. This is an excellent outcome given the difficulties in sourcing administrative support and having access to foot pressure offloading equipment. In the future we would like access to a lab for orthotic manufacture and a system for plantar pressure analysis.

In summary, the dedicated work of a motivated HRFS team with a mutual understanding of the importance of multidisciplinary, patient centered care, has given patients and clinicians involved in the service positive experiences and improved outcomes.

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