NorDocs

The quarterly magazine of the Northern Rivers Doctors Network

Autumn 2021

Slugs and snails and researchers' tales

The LARCS aren't singing

Virtual Reality helps healing

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The quarterly magazine of the Northern River Doctors Network

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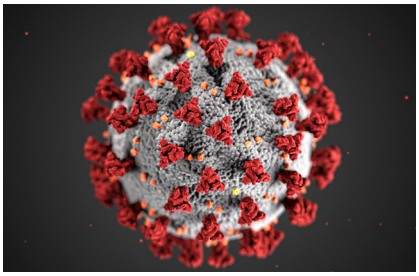

Photo by Tmaximumge form PxHere

Cover photo: Our cover does not depict the coronavirus 2 (SARS-CoV-2), a.k.a. COVID-19, pictured above, but an uncanny look-alike, the Janolus nudibranch, photographed by marine scientist Prof Steve Smith from Southern Cross University.

To borrow the words of Sir David Attenborough, Prof Smith must have "one of the best jobs in the world", and in this instance he was working in sheltered rockpools along the Coffs coastline, around the Solitary Islands.

Less attractively known as a 'sea slug', this creature is part of a large and distinctive family found along much of the Australian east coast.

Working further afield is another SCU researcher, Dr Steven Purcell, whose focus is the 'sea snail', more accurately the trochus, which he found to be having a positive ecological impact on coral reefs in Samoa.

A healthy environment is essential for the physical and mental wellbeing of us all, and NorDocs is pleased to be introducing a regular 'Environment' section to our magazine.

We are not ignoring the ongoing impacts of COVID-19 – if only! – and the impending vaccine rollout. Unfortunately, the pandemic story seems set to continue all year, and probably beyond. If anything can be predicted it would be to forget international travel and to enjoy life within our own safer borders - and our magical waters.

Cover photo: Professor Steve Smith, Southern Cross University

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Editorial

Vaccine monitoring is up with the AIR

David Guest, Clinical Editor

As summer ended we read the news that COVID-19 related deaths in the USA exceeded 500,000 - that's deaths, not cases - while in Australia the case tally stood at under 10, with no new cases in NSW at the time.

Phase 1a of the Australian **Covid-19 vaccination national roll-out strategy** has just commenced. It will take the rest of the year to vaccinate the majority of the over-fifty years population but once 70,000 quarantine border workers and 100,000 high risk health workers are vaccinated by early April the rest of the country can exhale with a big sigh of relief.

It is a tribute to Australia's health system and our public health workers that we have weathered this storm better than nearly every other country. There is the feeling that life is getting back to normal, although the 'new normal' is still spoken about. Australia's unemployment peaked at 7.5%, which was less than predicted, with the recovery in job numbers in the last four months being strong and much **faster than in previous recessions**.

The Federal and State governments of all persuasions, and their Oppositions, have united behind the efforts to contain and manage the virus and the downturn in the economy. They have mostly succeeded, with only occasional bickering when under the most extreme public (and media) pressure.

Australia as an island surrounded by a large maritime border, distant from other populous areas, has been in a fortunate position. Look at the situation in Indonesia or PNG. It has been easier for us, to bowdlerise former Prime Minister Tony Abbott, to "stop the viruses".

The Federal Health Department has stated that, "Rolling out the COVID-19 vaccine is one of the greatest logistical challenges in the nation's history." It will fall to general practice to deliver the vast majority of these vaccinations. The tasks are challenging at all levels of the program, from national to state and regional levels and even down to the pointy end at the GP clinic itself.

With so many unknowns and variables, and given the pressure to get the vaccine out with minimal delay, the task was never going to be easy. Some suggestions for the program that made their way into the initial plans may have been visionary but were clearly never going to work. They had survived the first round of brainstorming in Canberra and were "pencilled in" before more experienced administrators took control.

While it is easy to be critical, success will be defined as getting the majority of the Australian population vaccinated by the end of the year. Keeping things simple may be the key. A loose translation of 19th century German Field Marshal Helmuth von Moltke's remark, "No battle plan ever survives contact with the enemy" is apt.

Even as we start the program it is confusing to have two different vaccine treatments. The 'brand name' debate is hotting up in Europe as I write. This however merely reflects the difficulties of trying to manage a new and unknown disease. In early 2020 the Federal government was competing with other governments around the world for vaccines of unknown efficacy. Backing at least a couple of horses was only sensible.

Some vaccine efforts such as the University of Queensland's failed, not because they were ineffective, but because of other unforeseen effects. UQ's vaccine would have rendered many Australians positive for AIDS; falsely positive, but what alarm that would have caused.

It is therefore unlikely that the current Pfizer and AstraZeneca vaccines that Australia has purchased will be the best choices in the future.

Monitoring the vaccination status of the nation has been entrusted to the **Australian Immunisation Register** (AIR). The Register has been tracking all vaccinations since 2016 and all childhood vaccinations since 1996. The COVID-19 vaccines have been added to the register.

Previous uploads of data from GPs to the AIR were voluntary and in some cases were incentivised by payments for lodging updates. Given the seriousness of the COVID-19 pandemic and the huge scale of the nationwide vaccination program, the government recently enacted the **Australian Immunisation Register Amendment (Reporting) Bill 2020** mandating compulsory upload of COVID-19 vaccination data records.

While most GPs would regard this as reasonable, given the nationwide crisis we are facing, many have been surprised at the harshness of the penalties for failing to lodge the data within a two-week period. In theory the penalties could amount to several hundreds of thousands of dollars. It does look pretty heavy handed.

The only way GPs could cope with the requirements to upload such a large number of vaccine record submissions is by using an automated system linked to the practice's usual electronic record system. These systems are now largely in place, which is quite an achievement but it does put the final nail in the coffin for non-computerised general practice.

GPs are also concerned about the logistics of roll-out of the vaccines nationwide. In recent years the Department has taken an increasing command and control approach to the delivery of influenza vaccines. Delaying the commencement of vaccination until mid-April and tightening the window for delivering the vaccine has put increasing pressure on general practice logistics. The difficulties have been further compounded by problems with the supply chain resulting in hundreds of hours of wasted practice time cancelling scheduled clinics and then scrambling to reinstate them when the supplies finally came through.

Adding two COVID-19 vaccines to this mix, each given at least a few weeks apart and separate again to the influenza vaccine, has the making of a logistical nightmare for thousands of practice managers around the country.

Editorial

continued from P3

While few GPs believe the rollout will be trouble free, coping with uncertainty and imperfections in the system is something with which most of us have had long experience. We'll probably muddle through.

On a brighter note - congratulations to Dr David Scott on receiving the Order of Australia Medal in the recent Australia Day honours. On page 5 Dr Brian Pezzutti marks David's many achievements leading to this award.

Technical solutions and technical problems abound in medicine just as they do in general life and some long for the "good old days". However, as Franklin Pierce Adams had noted, "nothing is more responsible for the good old days than a bad memory".

In this issue we report on a few of the many IT related innovations whose progress has been accelerated by the COVID-19 virus. On page 13 Well Mob outlines the resources they have developed to reach the indigenous community with assistance for the social and emotional wellbeing of their clients.

Last year's rains resulted in worsening allergies in the spring and also more mosquito borne infections such as Barmah Forest and Ross River viruses. Local councils in conjunction with the North Coast Public Health Unit are trialing an SMS notification program on the risks and preventative measures for these diseases (page 16).

On page 24 North Coast neuropsychologist, Lynne Ridgeway, writes about the ways in which virtual reality is being used in various conditions such as pain management, psychological and neurological disease. VR is not just for games, apparently.

Getting the right information to the right person at the right time is a goal of modern IT. In Who's Where (page 15) we look at measures to also getting it to the right place. Keeping track of where doctors are currently practising is an ongoing task that still requires manual updating by practice managers.

On page 36 Tim Marsh updates us on the Lismore Base Hospital eReferral system for outpatient clinics. The trial to date has been positive and its success makes it a possible model for wider dissemination throughout the LHD and State.

The North Coast Allied Health Association (NCAHA) is one of the five member organisations of the North Coast Primary Health Network. On page 32 they outline their vision for the North Coast. Their vision for patient centred, multi-disciplinary, team based, collaborative care echoes the same values as the **Australian Medical Home** model of care. Alas this concept seems to have gone out of fashion in government health circles.

NCAHA laments that the current approach is failing on the North Coast and they call for stronger inter-disciplinary integration and training, particularly for those dealing with chronic and complex care patients. Current health care funding models perpetuate the ineffective status quo and they challenge the government to once again innovate in this area.

GOBSAT guidelines (Good old boys sitting around a table) defined the traditional care pathways in a bygone era. They failed on multiple levels, not the least being the lack of an evidence base and nor were they patient centred.

The modern focus for organisations involved in health care is to build structures that reflect the local population and which truly represent their communities. Gone are the days of decree by the white male patriarchy.

On page 9 North Coast Primary Health Network CEO, Julie Sturgess, highlights the importance of diversity for local health organisations mirroring a similar thrust in Australia's top 300 ASX companies which has the interim goal of at least **30% of Board members being female.**

Reflecting this new push to diversity at the NCPHN, Ms Sturgess welcomes two eminent Australians to their Board. Among many other roles Graeme Innes is a former Human Rights commissioner and Kerry Stubbs is Deputy Chancellor of Western Sydney University. In addition to their wide experience the CEO notes they bring "expertise in the fields of law, social justice, advocacy, and high-level government and administration and add value and diversity to the organisation's strategic direction".

Two more vacancies on the Board are yet to be filled. The NCPHN Nominations Committee has identified two highly credentialed candidates from the corporate/charity sectors who are able to address the identified skills gap in the current Board structure. Their appointment is expected to be announced in the near future.

Leaving the Board in 2020 after nine years were previous Chairman, Tim Francis, a GP/anaesthetist from Urunga, Dr Chris Jambour, founder of the Grant Street Medical Centre in Ballina and former Director of Medical Services LBH, Naree Hancock, a North Coast administrator in health and education and Scott Monaghan, CEO of Bulgarr Ngaru Medical Aboriginal Corporation.

The new-look Board is better positioned to take the NCPHN from its former role of a support organisation for primary health practitioners to that of a lean, innovative, technically advanced and efficient commissioner of Commonwealth health services focussed on high value deliverables to the government. This new focus is succinctly elaborated in **NCPHN's 2020-2021 strategic plan.**

We wish them luck.

Other recent changes at NCPHN also reflect a lesser role for local health organisations in determining the NCPHN Board's makeup. While some see this as detrimental it does obviate any potential conflicts of interest where Board members were also associated with contractors to the NCPHN. This had been an area of particular concern to the Executive and the Department.

On page 7 we outline our vision for the Nordocs monthly webinar series and appreciate any feedback, recommendations or assistance with our education program. The Board hopes to reinstate face to face meetings once the vaccination program has reached relevant targets later in the year.

Closer to home, NorDocs also has a new Board, as we report on page 6. Local haematologist and new mum, Louise Imlay-Gillespie is the new Chair, with Nathan Kesteven staying on as Vice Chair. We also welcome GP, David Glendinning, to the Board where he will also take on the role of Treasurer.

NorDocs, like the rest of the nation, will remember 2020 as a year of turmoil and disruption. Few of us will miss it. However with new challenges, new directions and new blood we are eager to see what 2021 will bring us.

- David Guest

Dr David Scott awarded OAM

by Dr Brian Pezzutti

Dr David Scott is the recipient of well-deserved community recognition for his service to Australia, particularly in the area of anaesthetic services.

David arrived in Lismore 26 years ago and has served our community with diligence and distinction, both in the public and the private sectors, at a national and international level.

Along the way David has provided clinical leadership, training to young trainees, anaesthesia and pain management and consultancy, particularly in the area of Regional Anaesthesia.

His work with the College includes being the Founding Chair of the Special Interest Group for Regional Anaesthesia, and convening the Regional Anaesthesia Workshop of Queensland since 2005.

His efforts in education were recognized with his appointment as an Associate Professor at the Lismore Clinical School of the University of Western Sydney, and his holding a Visiting Professorship at the University of California, Sacramento and at the Uniformed University in Bethesda in Washington DC, USA.

At a local level, David was at one time the Director of the Department of Anaesthesia and Acute Pain Medicine at St Vincent's Private Hospital, Lismore.

Joining the Australian Society of Anaesthetists in 1988 David has held a number of senior positions with the Society, including being an executive counselor, Vice President 2014 – 2016 and President 2016-2018, and he is currently the Immediate Past President.

During the time of his Presidency, David was deeply involved on the Medical Benefits Schedule Review, and his direct liaison with the Federal Health Minister Greg Hunt ensured that the inappropriate recommendations of the Review Committee were not adopted by the Government. Had the Government adopted these recommendations patient care would have been significantly affected, and out of pocket cost would have risen sharply.

David led a dispute between the Anaesthetic Department and the Northern NSW Local Health District Chief Executive to gain changes to the sessional contracts for Anaesthesia services so that Lismore was positioned well to attract Anaesthetists to work in Lismore.

Combined with supporting the dynamic leadership of the Department and the focus on "training and retaining", Lismore now has in excess of 30 Specialists in Anaesthesia Pain Management and Perioperative Care, far more than any Country Region in Australia. His strong advocacy for evidence-based practice and innovation has been important for the continuing development of an excellent anaesthetic service for the people Richmond Valley.

At an International level, David has taught and lectured at many overseas conferences, and published a well-acknowledged book with Alwyn Chan at Liverpool Hospital on Regional Anaesthesia with Ultrasound Guidance.

David has served in the Royal Australian Air Force Reserves since 1990, currently holding the rank of Group Captain. He is now Clinical Director of Anaesthesia and Intensive Care for the RAAF. David has deployed overseas with the Australian Defence Force to Afghanistan and East Timor at great personal risk and considerable cost.

His deployment following the earthquake and tsunami in Bandar, Aceh (Indonesia) in 2006 saw him do outstanding work under the most demanding conditions.

I am sure David's colleagues would join me in applauding this well-earned recognition for his services to our community, contributions to the profession and advocacy at the highest levels of Government.

Connecting dads and their babies, a great start for life

The summer 2020-21 edition of NorDocs introduced the Focus on New Fathers (FoNF) pilot, a partnership between NSW Health and the University of Newcastle to deliver a free service to non-birthing partners of all cultures and genders.

Once a 'father' has enrolled through **www.health.nsw.gov.au/focus-on-new-fathers**, the father will receive regular text messages with tips, information and links designed to help them connect with and support their baby and partner, while looking after themselves as a parent.

Fathers and co-parents can now sign up from as early as 12 weeks into the pregnancy or up until 24 weeks following the birth of the baby, provided they are at least 14 years of age. The messages will continue until the baby is one.

From the program launch on 6 September 2020, there have been more than 125 fathers enrol from the Northern NSW Local Health District, nine of which identify as Aboriginal, and 1314 enrol across the state. Along with Northern NSW Local Health District, there are three other pilot areas; Northern Sydney, Western Sydney and Murrumbidgee Local Health Districts. At this stage, the pilot is continuing until 30 June 2021.

Healthy child development starts early and dads have an important part to play. General Practitioners and primary healthcare providers are in a fantastic position to be able to refer new parents to this free and easily accessible service.

If you would like to experience the service firsthand, there is a professional taster available to provide insight into the messages that fathers will receive. To sign up for this, head to **www.sms4dads.com**, scroll to the bottom left and click on 'click here for professional taster'.

Further information about the program can be found on the webpage, or by contacting the Northern NSW Local Project Coordinator, Emma Murray on 6621 1245 or **emma.murray1@health.nsw.gov.au**.

NorDocs Board 2021

Dr Louise Imlay-Gillespie is the new Chair of the Northern Rivers Medical Network (NorDocs) for 2021.

Louise came to the North Coast in 2016 and has worked as a haematologist at LIsmore Base and Grafton District Hospitals since then. She has recently returned from maternity leave on a part-time basis following the birth of her son, Fox. We congratulate Louise and her husband, oncologist Joe Gormally, on this happy event. Joe has also been a member of the NorDocs Board the past two years.

Louise was instrumental in organising various education events at Lismore Base Hospital, including the physicians' week-end and the NorDocs Unconferences in 2018 and 2019. Under her guidance NorDocs hopes to build further on the hospital based education program.

Dr Nathan Kesteven, the former Chair, stays on as Vice-Chair. Nathan has championed improvement in education and communication for all North Coast doctors. Louise and Nathan aim to foster improved communication and build stronger professional relationships between primary and secondary health care.

Also joining the Board is Dr David Glendinning. David is a former engineer and project manager who retrained as a medical practitioner here on the North Coast, first through the University of Wollongong training program and then in the North Coast hospital system. On page 38 David describes his journey into medicine and expands on this in a recent episode of Destination's podcast, where rural graduates talk of their decisions to become rural doctors. (See link on page 38).

David has also worked extensively with Lismore Base Hospital on various eHealth and JMO education initiatives. He was the Director of the Assistants in Medicine program last year that allowed final year medical students to act as interns with limited responsibilities. The program was devised as a way of increasing medical manpower in the hospital system during the early stages of the pandemic in preparation for the anticipated large numbers of patients who might have required hospital treatment for COVID-19.

David was also an unsuccessful candidate for 2021 Board membership of the North Coast Primary Health Network.

Continuing on the Board is surgeon Trafford Fehlberg. Trafford has worked as a general surgeon in a local private practice since April 2019, and before that in Timor-Leste. In November 2020 he was appointed as the inaugural staff specialist general surgeon at Lismore Base Hospital, and now consults from the outpatients clinic at Lismore Base Hospital. Trafford and his wife Zoe have also recently had a son, Tasman. We trust the demands of patients and children do not cause too many sleepless nights for them both.

Trafford's 2019 presentation on his **surgical experiences in Timor-Leste** is

in our 2019 webinar archive at Vimeo. Trafford has a particular interest in upper gastro-intestinal surgery and he will present on that topic in our 14 April Webinar.

Dr Helen Lloyd joined the Board last year and will continue on in 2021. Helen is a GP in Mullumbimby and is pursuing research on mammalian meat allergy which is one of the subjects in our next podcast on 17 March 2021.

We are sad to see Dr Bronwyn Hudson leave the Board. Bronwyn has organised our most recent webinar along with colleagues David Helliwell and Anthony Solomon on opiate dependence treatments. Bronwyn's article from 2018 on opioid treatment in general practice along with the associated webinar is found on our website. Bronwyn presented to the National Ice Taskforce in 2019 as we reported in GPSpeak magazine. We appreciate the work she has done for NorDocs and the general community over the last three years.

Dr David Guest remains as secretary, a position he has held for 10 years. However, he is now ably assisted by our administrative officer, Linda Ward. Linda has a background in nursing and practice management. She runs her own practice management consultation business and in the past has worked for the Improvement Foundation and the North Coast Primary Health Network.

NorDocs runs a number of **open email lists**. The pracman list goes to all Practice Managers in the Network's footprint. NorDocs-members is an announcement list for North Coast doctors, particularly those who are not on Facebook, and gp-talk goes to North Coast GPs. It mainly publishes announcements and subsequent discussions from the webinars and other general practice/NorDocs matters. Practice managers and members can subscribe from the list page at **https://lists.nordocs.org.au/postorius/lists/**.

The Board is keen to hear from members on ideas for activities, education events or any other matters of concern. The Board can be reached at "Nordocs Board" <**nordocs-board@lists.nordocs.org.au**> and for general inquiries and administrative matters contact "Info @ Nordocs" <**nordocs-info@lists.nordocs.org.au**> which is monitored by Linda Ward, our administrative officer.

NorDocs
Northern Rivers Doctors Network

NorDocs Webinar Series

The NorDocs webinar series commenced in August 2020 and is continuing in 2021. Meetings are now scheduled on a regular basis for 7.30 pm on the second Wednesday of the month.

NorDocs is an independently run organisation and receives no funding from the government or government related entities. As such it relies on its own activities, and sponsorship and advertising from its supporters. It is a model used by most publications around the world and by podcasts on the web.

Our webinars policy is to acknowledge our sponsors at the beginning and end of each podcast and grant them the opportunity to address the audience for one to two minutes. This occurs at the beginning of the meeting. To date only one of our sponsors has taken up this option.

It is understood by our sponsors and advertisers that they exert no control over the content or format of the presentations, which are determined solely by the presenters and the NorDocs webinar committee.

There are many webinars and podcasts available on the web today, some of excellent quality. However, the particular advantage of the NorDocs webinars is that they give local GPs the opportunity to hear and see the specialists to whom they refer regularly. We believe this makes for a better understanding of the issues that both GPs and specialists face in providing a sound, efficient and affordable service.

Our preferred structure is for case based learning that spans all sectors of the health system from primary and secondary to tertiary care, involving doctors, nurses and allied health professionals. The sessions are live and interactive, allowing practitioners to pose questions to the presenters in 'real time' as well as being recorded if members are not able to make it at the allotted time. However, we feel that the greatest value derives from being a participant.

The first meeting for 2021 held on 10 February 2021 was on opiate dependency treatment and was given by the North Coast D&A team of Bronwyn Hudson, David Helliwell, Anthony Solomon, Petra Liedel and Michael Burgess.

The schedule for the first half of 2021 is 'pencilled' in below but is subject to change.

GPs wishing to stay up to date with the webinar series or who have recommendations for future topics should join the **gp-talk email** list at **https://lists.nordocs.org.au/postorius/lists/gp-talk.lists.nordocs.org.au/** or write to "Nordocs Webinars" <**nordocs-webinars@lists.nordocs.org.au**>.

Date	Topic	Presenters
10 Feb	*Opioid Dependence*	*Riverlands Drug and Alcohol unit*
17 March	"Too much meat"	Susan Tyler-Freer, Helen Lloyd and Louise Imlay-Gillespie
14 April	Upper GI surgery	Trafford Fehlberg, Gratian Punch
19 May	Fertility Problems	TBA
16 June	Shoulder Disorders	TBA

New board members for Healthy North Coast

Healthy North Coast, the successful contractor for the federally funded North Coast Primary Health Network, has announced two high-profile appointments to its board of directors, Kerry Stubbs, the Deputy Chancellor of Western Sydney University, and Graeme Innes, former commissioner at the Australian Human Rights Commission for almost a decade.

Both share a deep passion for the health sector and are keen to contribute to their local communities, according to the Healthy North Coast announcement in early February.

"I have had a lot of experience in community health services, disability and mental health services, and in palliative care. I'm also particularly interested in Aboriginal health issues and initiatives," Kerry Stubbs said.

"I believe I can contribute something of value in understanding those issues from both the provider's and consumer's side."

Graeme Innes said, "I hope that I can bring a deep knowledge of the community sector, experience in governance, and a wide network of connections at all levels of state and federal government to the organisation."

Healthy North Coast CEO Julie Sturgess said she was delighted to be welcoming the new directors whose expertise in the fields of law, social justice, advocacy, and high-level government and administration would add value and diversity to the organisation's strategic direction.

"Together, they will help Healthy North Coast continue its drive to take a leading role in the ongoing health reform and improvement that is clearly needed in our region and nation.

"We will strive to succeed in not just 'meeting' but 'exceeding' our goal of delivering the Primary Health Network program in our regional footprint, from Port Macquarie to Tweed Heads, and the New England Tableland.

"We believe our communities are the ultimate beneficiaries of Healthy North Coast's successes and we are immensely proud to be delivering the PHN program."

The importance of diversity on boards

by Julie Sturgess,
CEO, Healthy North Coast

As the new year gets into full swing for Healthy North Coast, it is fitting to look at the role our board plays in shaping our future, and to celebrate the breadth of talent and diversity they bring.

With our recent appointment of two truly remarkable board members, Graeme Innes and Kerry Stubbs, I have been reflecting on the words of KPMG Australia's Chair, Alison Kitchen, in her introduction to Building Gender Diversity on ASX 300 Boards, published last June.

Alison wrote: "*... When you're operating in an environment where there's a huge number of unknowns – having a lot of different experience around the table is a very good thing. And that diversity of experience can help boards navigate the enormous challenges we are facing.*

"*...having different voices, different perspectives, different life experience and different business experience at the table – all asking open questions, being curious and sharing experiences, is the key to surviving and thriving. The advantage a diverse board offers is the ability for companies to be agile, flexible, and to think, quickly and differently.*"

2021 heralds an exciting new chapter for Healthy North Coast as we continue to serve the Mid and North Coast regions with an ambitious and locally focused PHN program, and the guidance of an experienced and diverse Healthy North Coast Board of Directors.

As we rise to meet the unprecedented challenges of the coming decade in health care, we will continue to focus on connecting with, and serving the needs of general practice, allied health, and our communities, through our four strategic pillars. This is a mission about which we are incredibly passionate and proud.

It is a real honour to introduce Graeme and Kerry – both local residents – as new board members.

Graeme is a lawyer and company director with more than 40 years of board, finance and business management experience.

New Healthy North Coast (HCN) Board members Kerry Stubbs (front), Graeme Innes and CEO, Julie Sturgess.

He was Australia's Race Discrimination Commissioner for three years and served for almost a decade as a former Commissioner with the Australian Human Rights Commission, developing significant networks with both federal and state governments, including in the areas of health and with First Nations People.

Graeme has been a registered mediator for many years, and has negotiated at all levels of society, from community mediation to the development of a UN treaty.

He has a strong diversity and inclusion mindset and leads this area of change as a non-executive director of Life Without Barriers, one of Australia's largest service providers in the areas of Aboriginal and Torres Strait Islander people, people with disability, asylum seekers and children in out-of-home care.

Kerry is Deputy Chancellor of Western Sydney University and has worked as an academic at both Sydney University and the University of Technology.

She has extensive human resources, research and teaching expertise in the areas of anti-discrimination, equal employment opportunity and social justice, as well as significant expertise in the human capital field, including previous roles as CEO of Northcott and Executive Director of St Vincent's Hospital Sydney.

She is a member of the Community Advisory Committee for the Australian Digital Health Agency; Advisory Council to the Australian Health Protection Principal Committee on Disability Pandemic Planning; and the NSW Government Domestic and Family Violence and Sexual Assault Council.

A former NSW Telstra Businesswoman of the Year in the Community and Government sector, Kerry is particularly interested in using design thinking to foster innovation and better co-design of services and systems for the people who use them, and in particular disadvantaged and minority communities.

Our choice of two new members with exemplary legal, social justice, advocacy, and high-level government and administration experience, reflects our commitment to creating a diverse board with wide-ranging skills.

Graeme and Kerry join our other highly valued board members, who together provide Healthy North Coast with an extensive range of knowledge, skills and expertise in local health care provision, clinical expertise, Aboriginal health, academia, community development, business and corporate management, accounting and finance, law and local government, and advocacy and social justice.

Having such a stable and diverse board to steer Healthy North Coast has resulted in clear direction and strategy, solid accountability and controls, and transparency. Our diverse board will continue to help us better serve and represent the needs of our community as we navigate the move to regional commissioning and new partnership structures with other organisations inside and outside of the healthcare system.

As with all Primary Health Networks, our contract with the Commonwealth Government dictates that we must have a diverse, skills-based board as well as clinical councils, to help us function and navigate the landscape that we are in. Our current board members include a specialist anaesthetist, a dentist, two GPs, and a senior public administration executive.

Vale Mungo MacCallum

by Robin Osborne

I dipped in and out of Mungo MacCallum's life for decades, starting with an introduction in the office in (old) Parliament House, Canberra that he shared with my childhood friend, the late Helen Ester (nee Cunningham), an accomplished journalist who held similar views of the Australian political class.

Helen worked for the Inside Canberra newsletter, later launching her own publication, Monitor. Mungo was writing for outlets far and wide. I was astounded that these bright sparks could turn out wonderful stories from such a claustrophobic office.

Mungo and I shared space and time in two media outlets, the quirky Nation Review and ABC radio's Double J where I interviewed him each afternoon for the Frontline news program: "So, Mungo, what's been happening in Australian politics today…?", and off he'd go.

Later, as editor of the Lismore Echo, I engaged him to write a weekly column that we titled, with his amused approval, 'Political Corrections'.

Along with the journalist gene I share Mungo's Wentworth family background, mentioned in David Lovejoy's tribute as being "hard to overcome, even when you choose left-wing politics". My grannie was a Wentworth, every bit as eccentric, and as intelligent, as Mungo, albeit from an earlier era.

For many years a tradition in the Mungo-Jenny Garrett household was a party marking the Feast Day of St Mungo (13 or 14 January, according to the calendar you choose), honouring a sixth century saint celebrated on Glasgow's coat of arms.

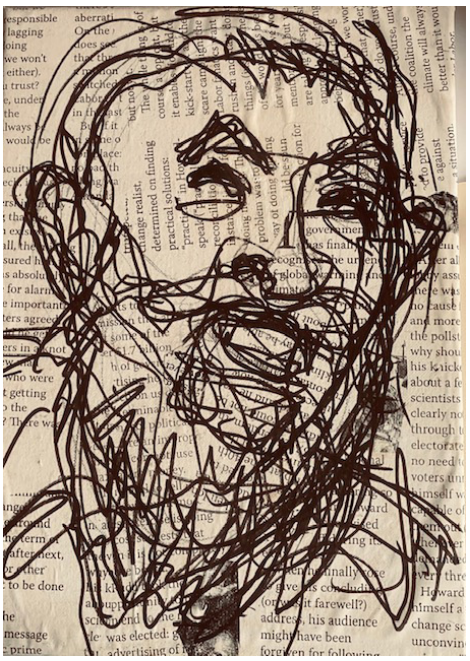
Arriving at one such event I noticed Mungo in his office, clattering away on his manual typewriter, ignoring the mounting revelry upstairs. I asked Jenny what he was writing and learned it was an obituary for a recently deceased, high-profile Labor politician. It was due to be filed that afternoon for the next days's paper.

Soon Mungo joined the feast honouring his namesake, and partied on.

I read the obit next morning – it was word perfect and insightful, amusing, irreverent… all the qualities that marked his columns and other writings over the years. Moreover, it had been written as a single draft on a typewriter, and faxed to Sydney.

The last time I saw Mungo was on the sad occasion of the funeral of our mutual friend Helen Ester on the Gold Coast in November 2015. Mungo wasn't up to driving by then, so I gave him a lift up and back, and we conversed as much as we could, given his dependence on a 'speech box' due to his laryngectomy.

We didn't stay for drinks and the drive south was a largely silent and sombre one.



Mungo (Felt pen on Echo newspaper clippings) by Jeni Binns

A few days later Mungo's obituary for Helen appeared in The Sydney Morning Herald. As might be expected it was again word perfect: "In matters of belief and conviction she was unswerving to the end," he wrote.

Words that apply equally to Mungo himself.

Legend has it that St Mungo performed four miracles in Glasgow, which are also depicted on the city's coat of arms. One of them, I'm pleased to note, is that he restored life to a robin that had been killed by some of his classmates. This is some relief, although next time the bell tolls it may well be for me.

Link to the Echo's farewell to Mungo

The importance of diversity on boards

continued from P9

The board, including our new members, will help Healthy North Coast continue its drive to take a leading role in the ongoing health reform and improvement that is clearly needed in our region and nation.

We will strive not just to 'meet' but to 'exceed' all the goals of delivering the PHN program in our regional footprint from Port Macquarie to Tweed Heads and the New England Tableland.

Other Healthy North Coast board members:

- Dr Adrian Gilliland is a GP and co-owner of Coffs Medical Centre, a large, long-established general practice.
- Warren Grimshaw AM has extensive senior experience in public administration and the health sector. Warren is Chair of the Mid North Coast Local Health District Board, a position he has held since 2011.
- Dr Caroline Hong has a Bachelor of Dental Surgery, Graduate Diploma of Health Administration, and a Master of Health Administration. She is a Board Trustee of the St Vincent's Clinic Foundation and has been in that role supporting healthcare and medical research since 2012.
- Dr John Moran AM is Associate Professor of Medicine at the University of Wollongong; Assistant Professor at Bond University; and Sub Dean of Medicine at the University Centre for Rural Health (Sydney University). He has been a GP in Murwillumbah for more than 35 years as both senior partner and managing partner of King Street Medical Centre.
- Dr Joanna Sutherland is a specialist anaesthetist in Coffs Harbour, with a Master of Health Policy, and a Master of Clinical Sciences (Research). She is actively involved in teaching and training medical students (as a conjoint academic with UNSW Rural Clinical School), and training and supporting specialist and GP anaesthetists.

Slugs and snails and researchers' tales

by Robin Osborne

Slugs and snails may be unwelcome residents of terrestrial gardens but in the ocean they are being hailed for making positive contributions to the aquatic environment as well as delighting those fortunate to sight them.

In the forefront of 'sea slug' and 'sea snail' research are two Southern Cross University marine scientists, Steven Purcell and Steve Smith, the latter being fortunate enough to share his initials with these extraordinary creatures. He may even be able to say the words 'Sea Slug Census' three times quickly, although perhaps not under water.

At the end of January Professor Smith coordinated the third annual Coffs Coast Sea Slug Census, an event where "divers and rockpool ramblers" – another nice piece of alliteration – join forces to discover a significant number of nudibranch species. The flamboyant nudibranchs, less attractively known as 'sea slugs', are molluscs with reduced or absent shells, and they flourish in the waters of the NSW North Coast.

Professor Smith said, "The abundance of sheltered rock pools along the Coffs coastline, combined with the underwater habitat diversity around the Solitary Islands, provide a fantastic combination of suitable conditions for a large range of species."

With the support of the local diving group, Professor Smith created the first Sea Slug Census in 2013 at Nelson Bay, north of Newcastle. Since then, in conjunction with local naturalist and diving groups, the event has expanded to sites from the Gold Coast to Melbourne and offshore at Lord Howe Island.

"Participants simply find and photograph as many species of sea slug as possible and note the location. It's a citizen science program that offers fun, adventure and opportunities to learn about our remarkable marine biodiversity," Prof Smith added.

Meanwhile, in Pacific waters far to the east, SCU's other marine-researching Steven has been on the trail of an equally fascinating creature, the 'sea snail', more properly known as the trochus.

Professor Steve Smith

Dr Steven Purcell measuring trochus shell.

Gold spotted nudibranch

A polished trochus shell Credit: Steven Purcell

If Australians know anything about trochus it is because of the spectacular lustre of the shell, which, when polished, makes it the most popular source of mother-of-pearl buttons. The meat, which can be cooked in a variety of ways, is sold at Sydney Fish Market and is regarded as highly nutritious.

Now, as Dr Steven Purcell has confirmed in the journal Restoration Ecology, the trochus is having a positive ecological impact on coral reefs in Samoa where it was first introduced 15 years ago, long after it was well established in other Pacific countries as a valuable shellfish resource.

Noting that he had found no negative ecological effects of the trochus in colonised Samoan coral reefs, Dr Purcell wrote: "It's a story of the amazing colonisation of snails that appears to benefit both the marine environment and the livelihoods of the Samoan people.

"Unlike examples in Australia – the cane toad, the fox, rabbit and European carp, to name a few, which have been detrimental to native species and habitats – the trochus has shown itself to be a welcome species that can control reef algae while offering a valuable new seafood to coastal people."

Several years ago the Australian Centre for International Agricultural Research (ACIAR) commissioned SCU to partner with Samoa's Ministry of Fisheries in the study.

"From a few initial release sites, trochus now can be found around both main islands in Samoa. At many reef sites, populations are abundant, with several hundred animals or more per hectare," Dr Purcell said.

"A vibrant fishery has been established in Samoa, where artisanal village fishers collect them for local consumption and sale by the roadside."

In recent years, reefs in Samoa and elsewhere in the Pacific have been impacted by coral bleaching and subsequent algal overgrowth. Other studies show that trochus can benefit reef systems. Through its feeding, the herbivorous snails graze down this algal overgrowth that can smother young corals or prevent them from attaching on the reef.

"Our data found the introduced trochus in Samoa do not appear to be out-competing the native marine snail species," Dr Purcell said.

The LARCS aren't singing in Australia

by Andrew Binns

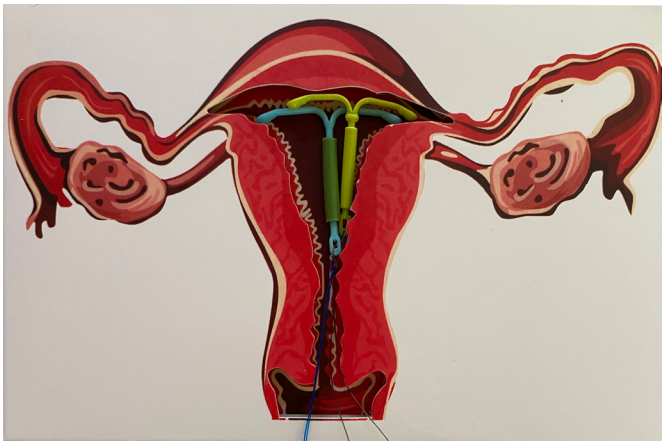
Noteworthy stories in the medical media have highlighted a general lack of education and procedural training for GPs around the topic of long-acting reversible contraceptives (LARCS), used by 12% of women in Australia compared with 15% in comparable countries.

Although usage has increased in recent times, we still lag behind other countries, and the uptake rate has plateaued rather than increasing.

Compounding the dilemma are our sky-high hysterectomy rates, which according to a recent OECD report are much higher than they should be. For example, Australia does about 250 hysterectomies/1000 women compared with, say, Denmark at 20/1000. New Zealand has half our rates, while Finland has decreased its hysterectomy rate by 60% in the last 20 years.

Professor Jason Abbott, UNSW Faculty of Medicine, commented in AusDoc 2020 (12 October, 2020) that we have one of the highest hysterectomy rates in the OECD and that although the rates have fallen the reduction has not been fast enough.

Prof Abbott says this is due to low awareness in primary care alternatives to treat menorrhagia and a lack of training in minimally invasive endometrial ablation procedures, particularly in rural and regional areas.



So, what could be done at the primary care level to address these concerns?

More training in LARCS procedures, particularly insertion of etonogestrel implants (Implanon) devices and the levonorgestrel intrauterine system (Mirena and Kyleena IUCDs), would help as these reduce menstrual bleeding.

There is some talk of this role partially being taken over by trained RNs, which may fragment care if not performed in the GP setting. That said, specialised family planning clinics fulfill an important complementary role for many women and offer valuable training opportunities for GPs.

I was involved in the first family planning clinic in Lismore. It started about 40 years ago and was a controversial topic amongst GPs. We did IUCD clinics at that time and I am pleased to say the devices have improved vastly since then. The old devices such as Lippes Loops and Copper 7s had a much higher infection rate than the modern devices, whether hormonal or copper.

IUCDs have had their ups and downs in reputation over the years, but the newer devices are safe, with minimal side effects and are generally well accepted by those women who use them.

More training for GPs at all levels is a high need. For those who would prefer not to be trained in these procedures, encouraging the use of LARCS rather than just the OC pill for contraception would be beneficial for both contraception and reducing menstrual bleeding. Added to this are the benefits of minimising unplanned pregnancies that can occur through poor compliance, including remembering daily oral contraceptive pill taking.

One new(ish) device on to the market to help encourage the use of LARCS is the Kyleena, released in March 2020. This device not only provides safe contraception for five years but reduces menstrual loss. It is also suitable for use in nulliparous and younger women. Women with menorrhagia would be best suited to a Mirena, which contains a higher dose of levonorgestrel.

The Kyleena is a smaller device than the Mirena, and is indicated specifically for contraception. The comparison of these devices for patients is shown in the following table.

Consideration	Kyleena	Mirena
Risk of pregnancy over 3 years[2,7]	Slightly higher (2%)	Lower (0%)
	Difference is not statistically significant but may be clinically significant for women.	
Risk of ovarian cysts over 3 years[7]	Less likely (8.6%)	More likely (22%)
	Difference is statistically significant.	
Bleeding and spotting days over 3 years[7]	More likely due to lower progestogen	Less likely due to higher progestogen
Dimensions / ease of insertion and removal[4,5,7]	28 mm width, 30 mm height: may be easier to insert/remove due to smaller size	32 mm width, 32 mm height: may be more difficult to insert/ remove due to larger size
Partial or complete expulsion over 3 years[2,7]	Low risk (2%)	Low risk (1.6%)

WellMob – your 'one-stop shop' website for Indigenous wellbeing

Finding online resources that support the mental health and wellbeing needs of Aboriginal and Torres Strait Islander people has been made easier with the development of a new website called ***WellMob***.

WellMob website team: Dr Judy Singer, Talah Laurie, Sharnie Roberts and David Edwards

"It was like looking for needles in haystacks to find culturally safe, Indigenous-specific wellbeing resources," says Worimi man and project Co-Director, David Edwards. "Most people just used Google, but it was hard to narrow down to Australian Indigenous online resources that were evidence-based or had been vetted to ensure cultural-safety for our community."

David and the *WellMob* team work part time at the University Centre for Rural Health (Lismore) and helped develop the website under the national **eMHPrac** (e-mental health in practice) project in collaboration with the **Australian Indigenous HealthInfoNet**.

What is *WellMob*?

The *WellMob* website has over 200 practical and effective videos, apps, podcasts and other websites together in one place. It's been designed to help our diverse health and wellbeing workforce to find and recommend online social and emotional wellbeing resources for their Indigenous patients/ clients.

Click here for the website promotional video

Why develop *WellMob*?

The inspiration came from frontline Aboriginal health and wellbeing workers here in Bundjalung country, northern NSW. They saw the need for a 'one-stop shop' of culturally relevant resources to use with their Indigenous clients. The *WellMob* website was developed to fill a cultural gap within the digital mental health space. One of the local health workers stated:

> 'We need digital resources across a wide range of topics, such as healthy living, connecting with country, dealing with grief, identity etc. that fit within a social and emotional model of care'
>
> Anonymous Health Worker, 2016

The *WellMob* team acknowledge the guidance of our website development reference groups in Larrakia (Darwin, NT), Kaurna (Adelaide, SA) and Bundjalung (Lismore, NSW) country. Through the dedication of these people, WellMob was developed so it could meet the needs of the many different Aboriginal and Torres Strait Islander communities as part of their wellbeing practice.

How can we use the *WellMob* website?

The website landing page has 6 main topics you can search under for your Indigenous clients or for your professional development. These wellbeing topics include: Mind; Body; Our Mob; Culture, Keeping Safe; and Healing.

Under each of these main health topics there are numerous sub-topics you can also search under. There is also a search and advanced search function that allows you to refine what type of resource and what subject matter you are looking for.

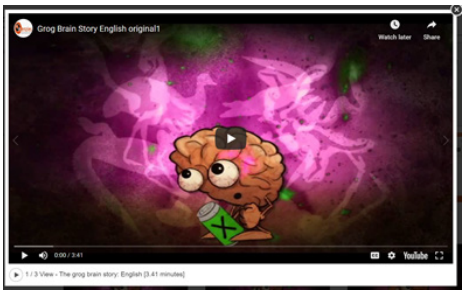
The website is a useful tool for our GP and allied health community to use both in and out of session. Some case studies to give examples are shown below:

Case Study 1 – 'The Grog Brain Story' (Menzies School of Health Research)

Showing a young person a short video on a health topic can be a great way to discuss a sensitive issue such as alcohol misuse.

See The Grog Brain Story link here.

Case Study 2 – Coping with the impacts of Trauma (The Healing Foundation)



Printing a brochure to explain to a patient how experiencing a trauma such as abuse can be triggered and some coping mechanisms that may support them.

See Coping with the Impacts of Trauma brochure link here.

Health promotion videos – the digital talking stick

Health workers wanted the website to contain lots of video content using storytelling techniques to supply information, rather than just giving a set of facts. "Our mob often learns and connects with information through story," says David.

"It doesn't have to be an evidence-based, online counseling program every time. It can be something as simple as a video that talks about someone's challenges dealing with stress, anxiety or depression, and how they overcame them through connecting to support."

WellMob – your 'one-stop shop' website for Indigenous wellbeing

"It can be a really great way for a non-Indigenous clinician to build rapport with an Indigenous client too. They're able to say, 'Look at this fella, he's really inspiring.'"

This idea of focusing on positive, strengths-based tools is an important part of the philosophy behind *WellMob*. "I think it's nice to have those more positive stories – to sell the strengths of our culture and how we can reconnect in times when we're feeling sad, worried, or stressed."

And though the idea of bringing these resources together in one place was developed long before the pandemic began, David and the team see the site as even more crucial during the restrictions and uncertainty of COVID-19.

Recorded webinars & CPD

The *WellMob* team have collaborated with the Black Dog Institute to develop some webinars about the website and using online resources with your Indigenous clients. You can register for a free webinar titled ***Supporting Indigenous wellbeing through digital resources: an introduction for clinicians*** here.

Want more information?

We are fortunate to have the website development team based in our region at the University Centre for Rural Health in Lismore. If you would like the team to send out some free 'calling cards' for you to write online resources down and leave with your client, contact David at E: **d.edwards@sydney.edu.au**.

Also follow the WellMob project via its **FaceBook page here**.

Who's where?

by David Guest

Many North Coast practices communicate electronically with each other. This is particularly useful for general practitioners sending referrals to specialists and for specialists, radiologists and hospitals sending reports back to the patient's general practitioner.

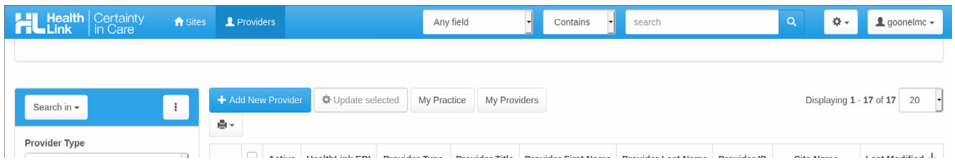
This form of communication is supported by private companies known as secure message delivery (SMD) providers. On the North Coast the SMDs **Medical Objects** and **Healthlink** are the most widely used.

Medical Objects

Medical Objects is the more commonly used by GPs and specialists to communicate with each other since it makes the process of sending letters and referrals relatively simple. The Medical Objects software installs a miniweb server at each surgery that gives information on the status of the letters the practice has sent and received. The sent letters can be in one of several states, namely "dropped, undelivered, processing, delivered but not yet imported and delivered and consumed". The last signifies that the message has successfully reached the intended destination. The others assist in troubleshooting communications that have gone astray.

The vast majority of reports reach their destination in less than 24 hours and usually within minutes during office hours and require no intervention by the practitioners of their staff.

Healthlink



Sending letters via Healthlink is simpler than Medical Objects. It is a one click process. However, it does require the recipient's Healthlink code to be entered in the electronic health record's (EHR) address book prior to any transmission. The interface to the status of the transmitted documents is also not as clear as Medical Objects'.

However Healthlink's SmartForms have revolutionised the completion of Transport for NSW's medical driving assessment submissions. The forms are also being used by general practitioners for submitting applications for Aged Care Assessments and locally for referral to the increasing number of specialist clinics at Lismore Base Hospital.

Service Registration Assistant

Many medical practitioners move practices each year. This can be out of the area completely for either family reasons or for appointments to other institutions as part of one's training. Locally GP registrars may move to a new practice every six months. It is therefore difficult for hospitals, pathologists and radiologists to maintain accurate databases of the current location for all medical practitioners.

The Australian Digital Health Agency has addressed this problem by creating the Service Registration Assistant (SRA). The rationale behind the SRA is that the practitioner information held in the practice's EHR is usually current.

This is true since doctors are not eligible for Medicare rebates if their details are not first lodged and approved by the Department of Health. Similarly doctors who leave are removed from the system or made inactive so that the practice does not incur charges from the EHR provider for that former practitioner. A typical charge for a doctor license for an EHR is $1,000 per year.

The SRA system works by periodically updating an online database with the latest information. These changes are then sent to other health agencies, laboratories and hospitals. Individual practices can specify which services are updated with the current information.

The initial trial of the SRA was run as a partnership between North Coast general practices, the North Coast Primary Health Network and the Northern NSW Local Health District and was deemed quite successful.

A Phase 2 of the project has recently started with the aim of further streamlining the process. A User Reference Group was formed late last year and meets monthly to report back on the changes being proposed and / or made to the application.

Keeping SMD databases updated

In the interim for those not in the project the process of updating your current doctors list remains a semi-manual process.

Healthlink

Log into your **online portal** and select Add New Provider.

Fill in the details, save and you are done.

To archive a previous user simply uncheck the Active box.

Medical Objects

Medical Objects has a somewhat clunky **online web interface** for updating users. If however one uses the same browser for subsequent updates and that browser has retained previous entries in dialog dropdown boxes, the entry of previous values is much quicker and easier.

However most practices will find it easiest to download the pdf form and email or fax off the update. Medical Objects updates received forms within minutes during business hours.

The process is similar for **removing doctors** but once again the manual pdf is quicker and less frustrating.

The Future

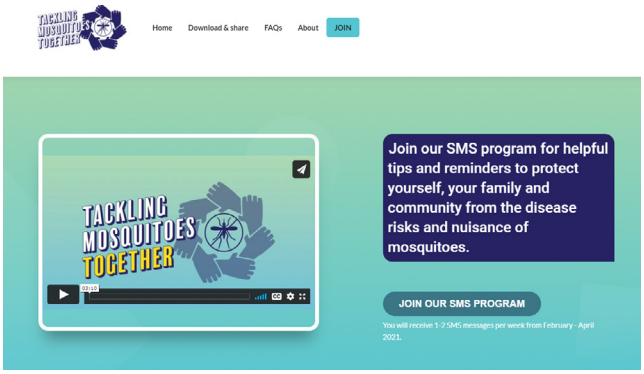
Covid-19 accelerated many new electronic capabilities in Australia's health system. It is unknown if the pace of change seen in 2020 will continue into the future but the trend is towards faster, more reliable communication.

"The right information to the right person at the right time" is the mantra. We are getting closer to that goal.

Phones swat virus-bearing mozzies

SMS messages delivered to local residents' phones are a new public health strategy to help reduce the likelihood of people contracting the debilitating, mosquito-borne Ross River and Barmah Forest Viruses.

Northern Rivers councils have teamed up with the North Coast Public Health Unit to launch a campaign dubbed 'Tackling Mosquitoes Together', which focuses on delivering free text messages offering tips and tools for protection.



The initiative is being offered through the website **www.tacklingmosquitoestogether.com.au.** It is prompted by the high number of virus notifications in recent times. Byron Shire Council's Team Leader Environmental Health, Enzo Picerni said 429 cases of Ross River Virus were reported last year by the Northern NSW LHD, the second highest number on record, up from an average of 135 cases a year over the last 30 years.

Ross River virus is named after the Ross River in Townsville, while Barmah Forest Virus was first identified at the opposite end of the country, in northern sub-tropical Victoria. There is no vaccine or treatment for either disease – those afflicted must wait it out, suffering from a range of symptoms that may include joint inflammation and pain, fatigue and muscle aches, and rash. These can be persistent, and even recur over years.

Those joining the SMS program will receive advice on protection against mosquitoes as well as an education pack and mozzie repellent. The text messages include videos, images and mozzie myth busters, as well as information on seasonal and weather factors, including tides and rainfall events to help participants reduce risks at the most effective time.

Late summer and early autumn is the peak period for infection, and Northern Rivers residents are being encouraged to wear long, loose fitting clothing, especially at dawn and dusk, and to take action by reducing backyard mosquito breeding habitats.

Mental health inquiry calls for a sectoral 'refocus'

by Robin Osborne

There were few if any surprises contained in the Productivity Commission's inquiry into mental health, with the **near-final report** delivered to the Australian Government in June made public near the end of 2020.

Some 63 pages into the 1273-page document the reader sees 21 key recommendations emerging from widespread community consultations and the deliberations of three eminently qualified commissioners, led by Professor Stephen King from Monash University.

1. Create a person-centred mental health system? Tick.

2. Support the social inclusion of people living with mental illness? Tick.

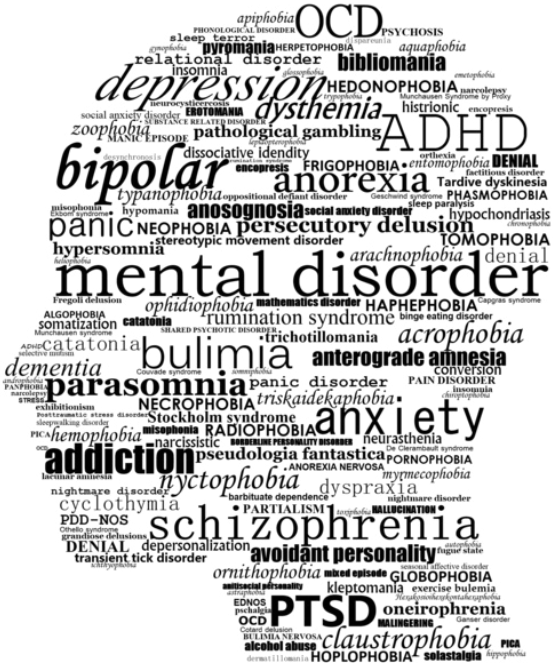
3. Focus on children's wellbeing across the education and health systems? Tick

4. Support the mental health of tertiary students? Tick

5. Take action to prevent suicide? Tick, tick, tick

The report identified many shortcomings in the mental health system – otherwise, presumably, there would have been no need for the government to commission such a major inquiry. In this regard it resembles the findings of the Royal Commissions into aged care and disability services, previously covered in this magazine. Not surprisingly, there is a degree of overlap, as the focus of all such investigations are Australians who, in one way or another, might be regarded as 'doing it tough'.

The commissioners note that, "Australia's mental health system does not focus on prevention and early intervention. Too many people are treated too late. Young Australians at risk and their families cannot easily access support.



Paget Michael Creelman, CC BY-SA 4.0 ,Wikimedia Commons

And those with developing mental health problems can face a bewildering array of unpredictable gateways to care: they know what services they need, but timely access is not possible."

They add, "Our recommendations aim to refocus the mental health system, recognising the truth in the adage that 'prevention is better than cure'."

As with all such reports, the onus for action rests with the government, which controls the coffers that must be utilised to effect most of the identified reforms. Improve the experience of mental healthcare for people in crisis? Tick. Improve outcomes for people with comorbidities? Tick.

"Australia's mental health system does not empower those who need it," the commissioners continue.

"People with mental illness often have little say in their own treatment and are deprived of the information and other resources that they need to manage and make decisions about their own care.

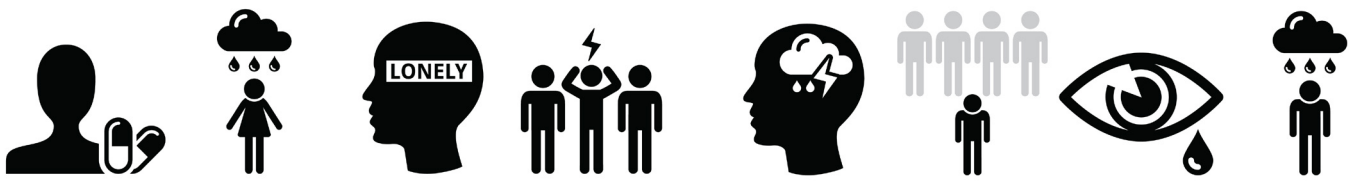
"Providers of clinical and community services too often deliver what they think consumers need, sometimes based on ill-informed assumptions about the decision-making capacity of the consumer and sometimes based just on the symptoms presented to them rather than a holistic view of the individual.

"Our recommendations aim to empower the service users, in partnership with their families and carers, to have real input into the health decisions that affect their lives. In part, this will require community-wide efforts to reduce the stigma that acts as a barrier to informed choice and deliberate steps to prioritise the recovery of people within their communities.

"Put simply, Australia's mental health system is not 'person-centred'. It should be."

While attitudinal change certainly has budgetary implications, money alone cannot solve all the problems identified, given the dimension of the challenge: in 2014-15, four million Australians reported having experienced a common mental disorder, and as the report notes, "Employers, not-for-profit organisations and carers also play key roles in the mental health of Australians. Many businesses are developing initiatives to support and maintain positive mental health outcomes for their employees as well as helping employees with mental ill-health continue to participate in, or return to, work."

The government has welcomed the near-final report (the first draft **was reported in GP Speak in Dec 2019**) and invited comments (closing 10 Feb 2021) on the recommendations. The ball is now back in its court to determine what action will be taken, and within what timeframe. Millions of Australians, including their family members, friends, carers and treating clinicians are eager to see the responses.



Massive health spend delivers mixed results

More than 1-in-1000 deaths in Australia is potentially avoidable, according to newly released data, despite government expenditure on health services reaching the seemingly astronomical figure of $133.6 billion. The actual figure of 105.7 potentially avoidable deaths per 100,000 people was four more than in the previous year (101.2 per 100,000), following annual decreases over the previous nine years.

The rate of potentially avoidable deaths in 2015–2019 for Aboriginal and Torres Strait Islander people – whose life expectancy is roughly ten years' less than non-Indigenous Australians - was more than three times the rate for other people.

The statistics are among those released in the latest **Report on Government Services (ROGS) 2021** compiled by the Australian Government's Productivity Commission -

Public hospitals comprised the greatest call on funding, at $72.2 billion, followed by primary and community health at $38.7 billion, and ambulance services at $4.2 billion. Expenditure on mental health services totalled $10.0 billion but as much of this expenditure is captured in the public hospital and primary community health expenditure it was not included in the health expenditure total.

The focus on GPs indicated that 11,482 (full time equivalent – 9765) worked in NSW, of the Australian total of 37,472. Surveys of patients showed that 3.7 per cent of the population had delayed or did not visit a GP in the last 12 months due to cost, while 6.6 per cent of the population had delayed filling or did not fill a prescription due to cost.

Nationally, the majority of respondents reported that the GP always or often:

- listened carefully (92.3 percent).
- showed respect (94.6 percent).
- spent enough time with them (90.9 percent).

Dentists were found to have fared somewhat better in each category.

Waiting times for urgent care GP appointments showed that 18.7 percent of people waited longer than they felt was acceptable to get an appointment:-

- 59.4 percent waited less than 4 hours
- 10.8 percent waited from 4 to less than 24 hours
- 29.8 percent waited for 24 hours or more, up from 24% in the past seven years.

In 2019-20, there were around 2.8 million GP-type presentations to Australian public hospital emergency departments.

The most common causes of death among all Australians in 2019 were cancers and diseases of the circulatory system (including heart disease, heart attack and stroke), though rates for both have reduced significantly in the past decade.

North Coast Cancer Institute turns ten

The highly-regarded, Lismore headquartered North Coast Cancer Institute is marking a decade of providing state-of-the-art cancer care to patients in the Northern Rivers.

The facility adjacent to Lismore Base Hospital opened in July 2010 at a cost of $27 million, jointly funded by the Commonwealth and NSW governments. The service model was to offer co-located radiation oncology, medical oncology and haematology.

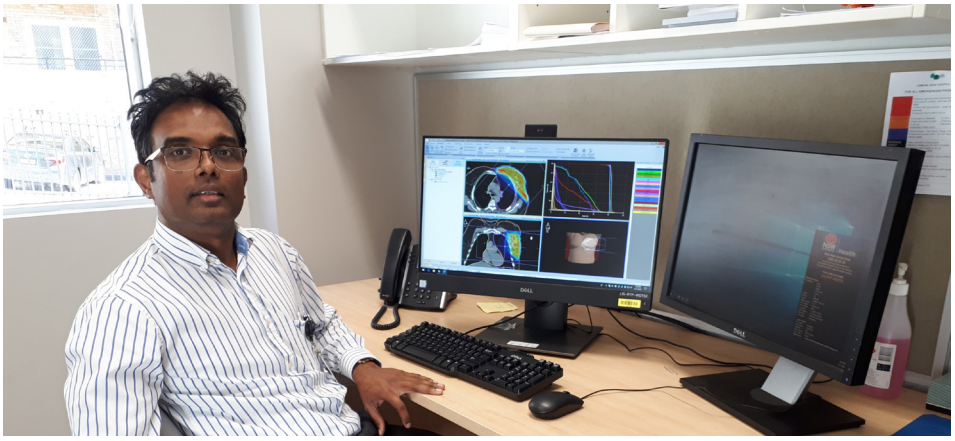
Since then the centre has grown to meet the expanding demand for cancer services in the region, providing more than 5100 courses of Radiation Oncology over the decade, offering patients locally-based expert care and employing more than 40 staff including specialists, nursing, allied health and support staff.

A new Surface Guided Radiation Therapy system was installed in July, with NCCI being the first cancer treatment centre in NSW to have this technology.

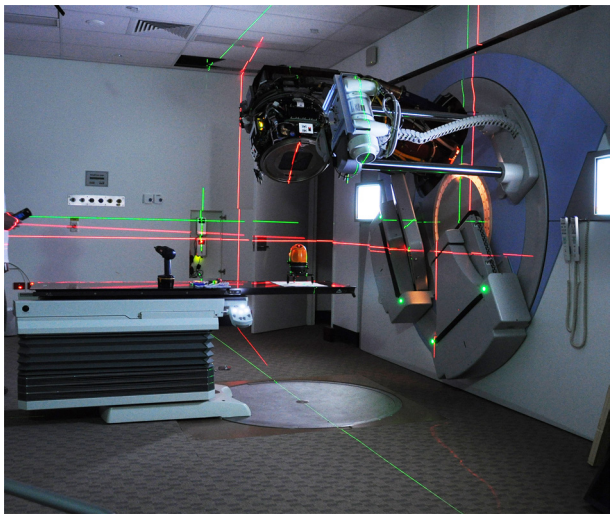
Radiation Oncologist Dr Julan Amalaseelan said the new system was a great advancement: “It uses a combination of projected light and cameras to provide a three-dimensional image of the patient’s body surface, instead of using ionising radiation as other imaging methods do.”

“The North Coast Cancer Institute is an integral part of our health network and the calibre of our staff is second-to-none,” added Lynne Weir, Director Clinical Operations, Northern NSW LHD.

NCCI staff and student with the new Surface Guided Radiation Therapy System, installed in July. L-R: Radiation Oncologist Dr Shreya Armstrong, Radiation Therapist Deanne Younger, University of Newcastle student Daniel Lowe and NCCI Chief Radiation Therapist Stephen Manley.



Dr Julan Amalaseelan, Radiation Oncologist



The installation of the linear accelerator (LINAC) at opening time in 2010.

“Our staff take pride in providing an excellent standard of care to patients, while furthering their knowledge and profession through research and innovation. Our staff have featured in peer-reviewed journal publications, local and international conferences, and received international recognition.”

The NCCI staff receive support from an army of volunteers who are dedicated to improving patients’ experience of care and journey through cancer diagnosis and treatment. They include the Cancer Council of NSW, to palliative care volunteers, Delta therapy dogs, local charity organisations, church groups, Rotary clubs, sporting events, individual community members.

“We are incredibly fortunate to have so many dedicated volunteers giving their time and efforts to help others,” Ms Weir said.

This year, to keep staff and patients safe during the pandemic, the team at NCCI have implemented a range of measures to minimise risk of COVID-19 transmission, including rotating team members in separate work cohorts.

Radiotherapy for skin cancer – an overview

by Dr Shreya Armstrong

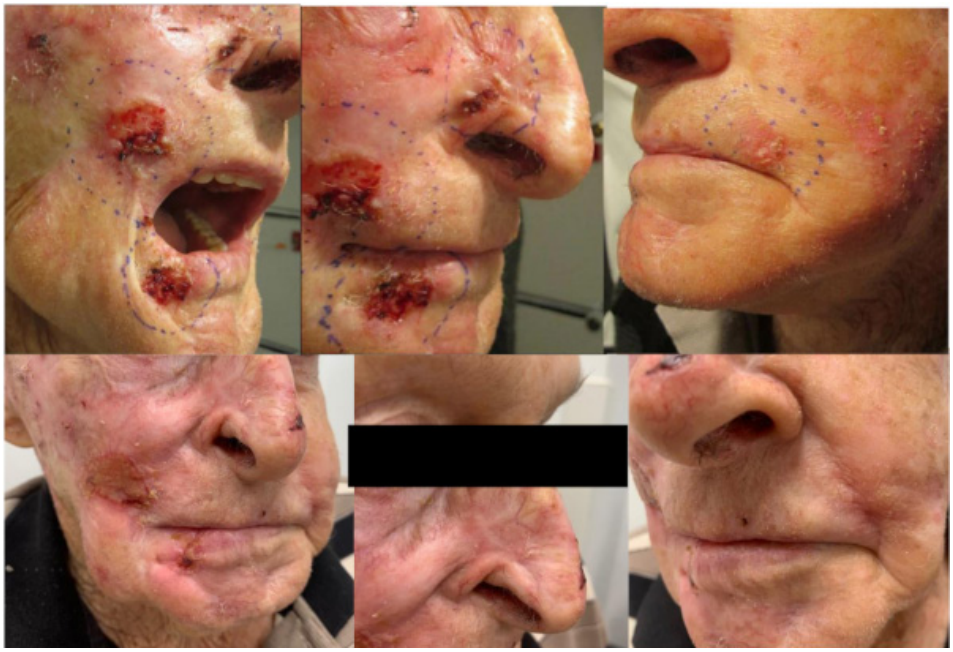
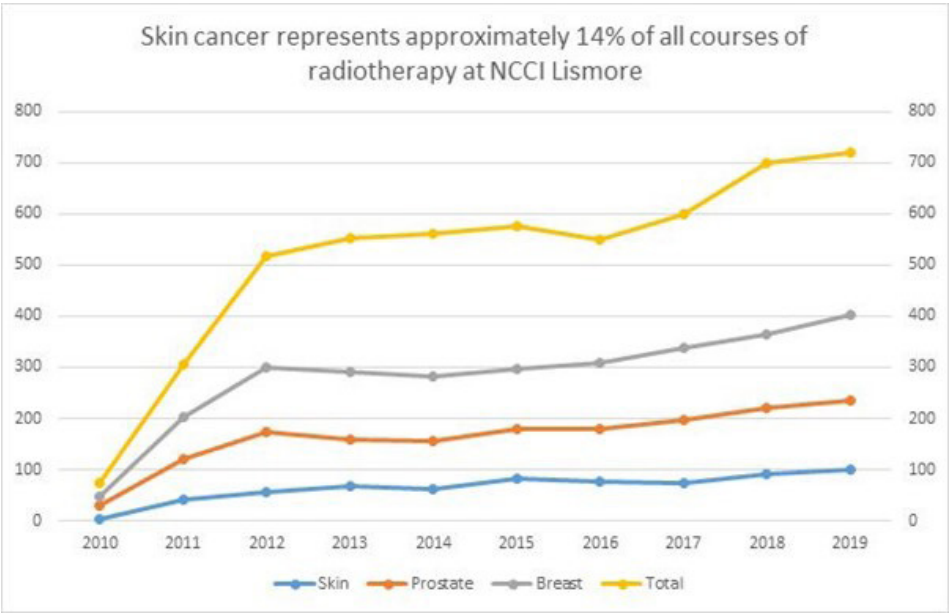


Figure 1 (above)

Epidemiology

Skin cancer accounts for the largest number of cancers diagnosed in Australia each year, with more non melanoma skin cancer (NMSC) diagnosed each year than all cancers combined[1]. The common NMSCs include[4] basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), with 35% increase in age standardized incidence of BCC and double the incidence of SCC from 1985 to 2002. Rarer NMSCs include but are not limited to Merkel cell carcinoma and dermatofibrosarcoma, with 900 new cases diagnosed in Australia in 2016, accounting for 0.7% of all cancers diagnosed. Australia also has the world's second highest incidence of melanoma, with 35 new cases a year per 100,000 people, accounting for 10% of all cancers diagnosed[1].



Treatment Options for Skin Cancer

The treatment options available for skin cancer includes topical therapies, surgery, radiation therapy, systemic therapy (including chemotherapy, immunotherapy and/or targeted therapy), either alone or in combination. The ultimate choice of treatment depends on the tumour type, tumour extent, patient fitness and patient preference.

Radiotherapy for Skin Cancer

For NMSCs, radiotherapy can be used as the sole definitive treatment modality, or in the adjuvant setting for tumours with high risk features to reduce the risk of local recurrence (see table below). Definitive radiotherapy may be considered for patients who are not a surgical candidate, present with an inoperable lesion, or where excision would produce loss of function or unacceptable cosmesis. Randomised data comparing different treatment modalities are lacking, however large series data report local control rates with radiotherapy in the order of 90-95% and excellent or good cosmesis in >90% of patients[3-7]. Merkel cell carcinomas (MCCs) are aggressive neuroendocrine tumours with high propensity for regional and distant metastases. MCCs are exquisitely radiosensitive, with two meta-analyses confirming the benefit of adjuvant radiotherapy, which is associated with significant improvement in locoregional control and overall survival compared to surgery alone. MCC may also be managed with definitive radiotherapy alone, with reported in-field control rate of 75%[8].

For melanoma, adjuvant radiotherapy may be considered for patients at high risk of local or regional recurrence. Randomised evidence has shown the addition of adjuvant radiotherapy for tumours with high risk features is associated with a statistically significant reduction in locoregional relapse[9].

Indications for post-operative radiotherapy for NMSCs (adapted from eviQ)[2]

Absolute

- T4 disease
- Positive margins, where further surgery not feasible
- Large nerve perineural spread
- Recurrent disease

Relative (consider when 2 or more present)

- T2 or T3
- Poorly differentiated

- Close margins (<2mm)
- ≥6mm depth of invasion
- Lymphovascular invasion
- Immunosuppression
- Pathological perineural invasion (nerve diameter ≥0.1mm)
- High risk tumour site (e.g. preauricular, ear, temple, non-hair bearing lip)

Management of Skin Cancer at North Coast Cancer Institute (NCCI)

At NCCI, skin cancer is the 4th most common tumour type treated.

The location, size, depth and overall volume of the tumour dictates which modality of radiotherapy is most suitable. According to the clinical parameters, patients at NCCI may be treated using superficial radiation therapy (SXRT) or external beam radiotherapy (EBRT).

SXRT is used to treat small tumours in eloquent and/or technically challenging locations such as lesions near the eye or nose. Majority of skin cancers are treated using EBRT, including superficial tumours that are not suited for SXRT and for tumours where larger and more complex volumes require treatment.

Technological advances in radiotherapy mean that complex surfaces such as scalp or regional lymph nodes can be treated at NCCI using modern EBRT techniques such as intensity modulated radiation therapy (IMRT) or volumetric modulated arc therapy (VMAT). These techniques allow for a sophisticated delivery whereby the high doses of radiation can be delivered to clinical regions at risk whilst minimizing unnecessary side effects.

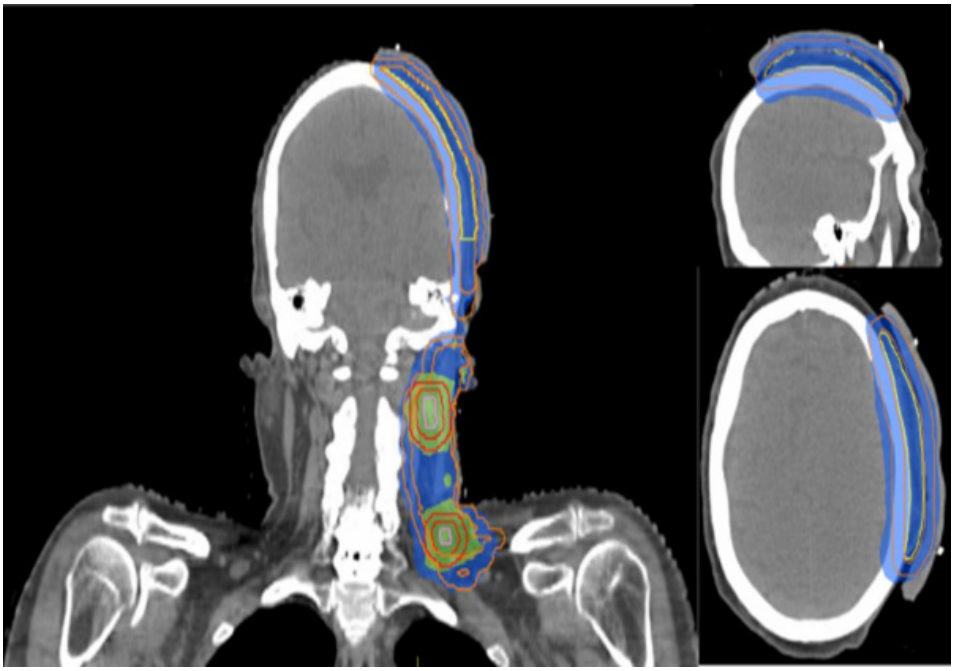


Figure 2 (above)

Radiotherapy dose to healthy tissues

Radiotherapy referrals to NCCI are received either directly (via general practitioners, surgeons or dermatologists), or more complex cases are discussed and referred through a multidisciplinary team meeting (MDT) pathway. Our local MDM is held fortnightly, and typically attended by surgeons, radiation oncologists, medical oncologists, pathologists and radiologists. We welcome the involvement of general practitioners at the meeting, which can attend either physically or virtually at Lismore Base Hospital.

Figure 1 (opposite page) illustrates a series of clinical photographs of a patient with multiple NMSCs prior to radiotherapy in the top row, followed by a series of clinical photographs following a course of definitive radiotherapy (using SXT), showing complete clinical response.

Figure 2 (above) illustrates a complex radiotherapy plan using VMAT technique for patient with high risk cutaneous SCC with pathological lymph nodes in the left neck. The blue and green highlighted areas represent the differential dose prescription to the overall volume, with a higher radiation dose prescribed to the pathological macroscopic neck nodes.

Dr Shreya Armstrong has joined Drs Patrick Dwyer, Julan Amalaseelan and A/Prof Tom Shakespeare at the North Coast Cancer Institute.

Shreya completed her specialist training in Radiation Oncology in 2014, having undertaken the first two years of training in New South Wales at Newcastle Calvary Mater Hospital and Lismore Base Hospital, before going on to Royal Brisbane and Women's Hospital and Princess Alexandra Hospital. She subsequently undertook the Windeyer Fellowship at Mount Vernon Hospital in the United Kingdom specialising in brachytherapy for urological and gynaecological malignancies.

She has had several papers published and has presented at clinical research conferences both nationally and internationally.

Shreya has a special interest in cutaneous, central nervous system, gynaecological and urological malignancies, as well as palliative radiotherapy for all tumour sites. She consults at the outpatient clinic at Lismore Base and at the soon to be established radiation outpatient clinic at Byron Central Hospital.

Shreya returned to the beautiful North Coast having been impressed by the area and its community when she first came as a registrar.

She can be contacted through the NCCI or at Shreya.Armstrong@health.nsw.gov.au or mobile on 0428 128 436

Robotic Surgery: Gynaecology

A Fact Sheet by Dr Erlich Sem

Leading Gold Coast Private Obstetrician and Gynaecologist Dr Erlich Sem provides the most up-to-date Robotic Surgical options for patients with Gynaecological conditions, including:

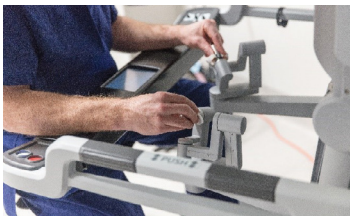
- Endometriosis
- Tubal Reanastomosis
- Colpopexy with hysterectomy
- Myomectomy

What are the benefits of Robotic Surgery?

The system allows the surgeon's hand movements to be scaled, filtered and translated into precise movements of micro-instruments within the operative site. The robotic instruments are "wristed" and have greater range of motions compared to human hands. These improved ergonomics helps to overcome the limitations of traditional laparoscopy. The surgeon's vision is greatly enhanced with 3D and high definition camera system, allowing better identification of pathology, such as endometriosis. These improvements are associated with reduced surgical time, improved and safer dissection of delicate tissues and less post-operative pain.

How is it performed?

Robot-assisted surgery mimics the surgeon's hands with robotic arms performing scaled-down, tiny movements within the body. The surgeon remains 100 percent in control of the operation, but the robot provides optimised 3D vision, magnification and motion tremor control, allowing the surgeon to operate high-tech instrumentation with greater dexterity and precision. The surgeon guides the procedure from a master console which controls robotic arms with attached surgical instruments.



Is there additional cost?

For most insured patients, there is no difference in cost when compared to standard laparoscopic approach.

Dr Erlich Sem

BMBS, MD, FRANZCOG (QLD)
Advanced Robotic and Laparoscopic Surgeon, Obstetrician and Gynaecologist

Dr Erlich Sem specialises in minimally invasive approach for:

- Hysterectomy
- Myomectomy
- Excision of Endometriosis with preservation of pelvic organs
- Ovarian Cystectomy/ Oophorectomy
- Division of Adhesion
- Pelvic Organ Prolapse Repair

To arrange an appointment with Dr Erlich Sem, contact:

Queen Street Specialist Suites
138 Queen Street,
Southport QLD 4215

P 1300 104 105
F 07 3905 1881
E info@drerlichsem.com.au

Gold Coast Private Hospital
14 Hill Street, Southport QLD 4215
P 07 5530 0300 | **F** 07 5530 0646
goldcoastprivatehospital.com.au

Of circuses, sideshows and high-wire feats

A Dickensian Sideshow – exhibition by Karla Dickens, Lismore Regional Gallery (Nov 2020 - Feb 2021, touring to Orange Regional Gallery in Nov 2021)

Aboriginal people were familiar faces in the circuses and carnival shows that toured Australian in the 20th century, crucial to the set-up and take-down work, the operating of sideshow alleys and the boxing tents run by the legendary Jimmy 'Who'll take a glove?' Sharman.

None, however, was more famous than Lismore-born Cornelius Sullivan, with an Irish father and part-Bundjalung mother, who went on to become one of the most famous circus performers in the world under the name 'Con Colleano'. Posing as a Spaniard because being Aboriginal wasn't saleable, he dressed like a matador and delighted audiences in Australian the USA and Europe for a high-wire balancing act that included full somersaults and removing his flowing cape in mid-air.

Highly paid by Ringlings and Barnum & Bailey, at one time he was considered a potential replacement for Rudolph Valentino after the silent film star died. He preferred the high wire and the gasps of live audiences. Con's remarkable agility – drawing gasps from gallery visitors - featured in newsreel footage about 'The Toreador of the Wire' that screened as part of Karla Dickens' celebration of the Indigenous people who boxed, ran sideshow attractions and helped keep all these community shows on the road.

Dickens, a woman of Wiradjuri descent now living locally, assembled, combined and modified 'found objects' collected over years as part of her art practice. They comprise an astounding grab-bag of memorabilia, from old sideshow signage – "Win a Tweety for your Sweety", and the Laughing Mouse Game: Every child player receives a prize – as well as original constructions.

The exhibition is vast, intricate to the point of overwhelming, and as might be expected, highly charged with comments on the racism that infected Aboriginal participation in popular culture, not least the kind that made 'Con Colleano' pretend to be Spanish, and sometimes even from the Hawaiian royal family. Of course, he had the last laugh, and the income to prove it.

One standout was a grotesque collage of masks, perhaps from a ghost train, bearing the caption, "True horror is Australia's history of massacring its first people".

The artist's found objects are immensely diverse, from advertising posters and sideshow games such as lucky envelopes and ping-pong balls, to boxing gloves and a spruiker's drum from the Sharman troupe's tent, souvenired by renowned painter and sometime boxer, the late Digby Moran.

Karla Dickens. Photo Mick Richards.

This strikingly original and deceptively challenging show contains a host of visual surprises as well as messages both subtle and blunt, the latter epitomised by the pig sculpture dubbed 'Lawless Piggy' that wears a NSW Police hat and bears the caption 'Warn a brother'.

The full exhibition and descriptions of the works come in a handsome 80-page book available for $30.00 through the Lismore Art Gallery or (02) 6627 4600.

Virtual Reality moves from gaming to healing

by Lynne Ridgway, Clinical Neuropsychologist

It was not that he was a Top Gun pilot, or that he took us to live in amazing cultures, but I finally agreed that my father was cool when he arranged to let us sit in his Mirage jet training simulator. However, military training simulators were mere toddlers in the evolution of Virtual Reality.

History of Virtual Reality

The earliest reference to 'VR' is from a 1935 sci-fi novel Pygmalion's Spectacles by Stanley Weinbaum in which a professor develops a pair of goggles so he can watch a movie with sight, sound, taste, smell, and touch. The idea became reality in 1957 when cinematographer Morton Heilig invented Sensorama, a multimedia theatre cabinet providing viewers with an interactive experience. The term Virtual Reality was not coined until 1987 by polymath Jaron Lanier's headset and interactive gloves.

This topic quickly dates, but now VR is used for entertainment, training and in health for treatment of medical and psychological problems. It is the big video games companies that have the expertise, skills and resources to lead technological developments that education, the military and health sectors are now utilising. The push for VR stemmed from a desire to figure out where interactive entertainment was going next.

Just for fun, or therapeutic?

Yes it's fun. Just ask Dr Jarrad if he enjoyed being Luke Skywalker! (photo top right)

For readers who haven't experienced VR, put simply, it's the difference between seeing a huge whale appear on your flat screen TV versus being (virtually) immersed underwater playing with fish and seeing a large whale swim up close to you. Or, how about Google street view on your laptop, versus walking (literally and virtually in your office) around the streets of Morocco or Paris, engaging most of your senses.

In my neuropsychology practice I have observed within-session changes in adults with neuropathic pain, functional movement disorders, and mental illness.

What about the generalisability of the gains to the real world? My impression is that education regarding pain management (somatic, psychological and social factors) is crucial, but that it is the immediate, highly salient experiential lesson gained during immersive VR experiences that demonstrates how we can override our brain's perception of pain.

Dr Jarrad (aka Luke Skywalker) Watt, Rehabilitation Consultant, using a virtual lightsaber to fight off attacking stormtroopers and defend the millennium falcon.

Case Summary 1.

Young male, ex-tradesman suffered a T5 complete spinal injury with a 2-year history of:

- Severe neuropathic pain - "It's all day and night. Nothing makes it go away",
- Depression- - "I only get occasional 20-second spikes of happiness", and
- Social withdrawal.

In therapy he appeared interested in education regarding pain management (the somatic / psychological / and social factors) but had been highly resistant to trialling any distraction techniques or activities.

In a debrief following a trial of 'The Blu' (15 minutes of hyper-realistic, interactive, underwater VR experiences) he commented, "This is f... awesome. What is this thing? Is that really what it's like underwater? I wanna do that".

Then I asked him a final question, "How was your pain?"

He went very quiet and looked in complete shock and disbelief, then replied "I didn't have any".

This one-off immersive VR experience was a powerful reinforcer of the theory we had discussed. He agreed and followed through on trying novel activities (he did not desire to do more VR or any other digital gaming) in the community to manage his pain. One year on, he has continued to recover psychologically, is more engaged socially, his mood has improved and he uses multiple distraction activities to supplement his pain management medications.

Recent developments

A large research group at the University of Southern California with US Army funding brings film and game industry artists together with computer and social scientists to develop immersive environments for military training, health therapies, science education and more.

In Australia, several universities are partnering with government and private health, including University of Queensland, Griffith University, Flinders University, Monash Brain Park, Australian Catholic University, to research virtual reality for health-related training and interventions.

Show us your evidence!

There have been 91 Cochrane reviews conducted over the last 10 years with the search terms "Virtual Reality Intervention'. The reviews cover topics of health and medical training, and interventions for a range of clinical disorders including stroke rehabilitation, multiple sclerosis, pain, serious mental illness, dementia, Parkinson's, conversion disorders and more.

While most studies show some promising results with no adverse side effects, the technology is developing so quickly that there is insufficient data in matched conditions to draw firm conclusions. At a recent international neurological rehabilitation conference with a stream dedicated to VR interventions, none of the papers were using the advanced technology I utilise in my clinic rooms - such is the lag between study design, data collection and publication compared to the technical advances.

The primary modest but important findings across VR rehabilitation studies to date are that patients show more 'interest in training' and are more likely to engage in longer duration rehabilitation activities in VR compared to with an individual therapist.

One recent Cochrane review found that fully-immersive virtual reality may reduce pain assessed by an observer based on children's behaviour (for example, crying, or rubbing a body part in a way that indicates pain) more effectively than non-virtual distraction or no distraction (Lambert et al 2020).

The consensus across current studies is that more high-quality research should be undertaken, and better evidence is required to make practice recommendations.

In the meantime, I explain the experimental nature of VR interventions to my patients with pain and functional neurological disorders and use pre, during and post monitoring of symptoms and video feedback. For individual patients getting immediate video feedback of the dramatic and obvious improvements in their pain experience or movement, pre-VR versus during-VR provides tangible confirmation to them that strong distraction can override their brain's experience of pain or functional movement disorder and promote enjoyment and participation in activity beyond the VR environment.

Virtual Reality in Health

1995 saw the first research papers published describing VR to create immersive exposure environments for treating fears and phobias including a Virtual Vietnam program to treat PTSD.

There has been an explosion of commercial programs available to treat a dizzying array of fears and phobias and skills practice for relaxation and stress management. I look forward to the day these become standardised and we can refer our patients to specific programs with confidence in the research evidence. Equipment costs are coming down, access is improving, and there is a great future in using VR across health education for patients and health professionals to engage in interventions for a range of physical and psychological conditions.

Give it a try and encourage research.

Finally, Australia Day this year revealed a fantastic project by Brett Levey creating a virtual reality program to celebrate First Nations cultures. Check it out. For more information see **Functional Neurological Disorders at https://fndaustralia.com.au/**

Case Summary 2.

A young high-achieving elite athlete fell and suffered a brief loss of consciousness and some persisting difficulties with balance, coordination and speed of movement that were described by the referring specialist as being 'functional' in nature.

In one session, a brief explanation was offered regarding how our brain can have a 'software glitch' leading to functional problems when the primary neurological "hardware" is normal. He was introduced to some fun engaging VR experiences before trialling "Beat Sabre". His wife videoed his VR exercise. The active ingredient in the intervention was when he replayed the video feedback immediately afterwards. The man and his wife commented on his obviously smooth, fast movements, great balance and upper limb coordination.

** Beat Sabre is a highly engaging VR exercise program with fun "doof doof' music and involves cognitive and physical skills including rapid hand eye coordination, decision making, impulse control, lower limb weight transfers and squatting and ducking out of the way of obstacles. Each 'song' lasts a few minutes before the player is given feedback on the number of correct contacts (and the level achieved).*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Timing is right for SCU's new health head

While not quite a frying pan-to-fire situation, Julie Jomeen has had an 'interesting' twelve months, leaving the UK as the coronavirus was starting to bite and arriving in Australia when the university sector began facing its toughest challenges in years.

Things would not get easier at either end, with Boris Johnson's government fumbling the COVID-19 response and Southern Cross University, to where Professor Jomeen was headed, about to axe 130 jobs amidst a devastating $33m budget shortfall. It wasn't alone, and universities continue to wobble as overseas student income dries up.

Welcome to your new life...

"Yes," Prof Jomeen confirmed in a Zoom call from the Gold Coast, near to the SCU campus that has seen significant growth in the last few years, "this was certainly the strangest start to a new job."

Nothing but an optimist, and coming straight from a gym workout, Prof Jomeen explained that she and the School has quickly adapted to the 'new normal', with the great majority of students in her School of Health and Human Sciences studying off-campus, in other words attending almost all their lectures and tutorials on-line.

Surveys show that many, perhaps most, Australian students don't like this, nor always do their teachers, regardless of how good the technology, but that's life in the age of COVID, and it's unlikely to change soon.

Prof Jomeen heads the multi-campus School's courses, which include nursing & midwifery, and allied health programs such as Speech Therapy, OT, Osteopathy, Podiatry and Pedorthics, as well as a human science course in Biomedical Science and Sport and Exercise Science. These have strong practicum arrangements with GP practices, hospitals and community health, the aged care sector, schools and allied health practices. If students miss out on face-to-face instruction they certainly make up for it with their hands-on work with patients and clients.

"SCU has been proud to maintain these placements despite the challenges of

COVID," Prof Jomeen says.

"Partnerships are key," she says, "nothing can operate successfully in isolation, and we have strong relationships with the LHDs [SCU works across both the Northern NSW and Mid North Coast footprints], Queensland Health, and the private hospital sector. We also collaborate closely the highly regarded University Centre for Rural Health.

"SCU is not just a key provider of education but an important civic institution, which includes our reach out into the community and having a large number of students from the local area."

Despite the tertiary education crisis, expansion plans are afoot for the School, including Social Work coming into its fold, along with a formal connection with the National Centre for Naturopathic Medicine (NCNM). On the horizon for the NCNM is a Masters of Lifestyle Medicine, reflecting Prof Jomeen's belief that, "Our society will have an ever-greater focus on preventive health and health promotion, wellness, and the various benefits of keeping us at home when we do fall ill."

Keenly aware of Indigenous health indicators, Prof Jomeen wants to embed Indigenous health in all the School's courses and research focus, along with boosting the number of Aboriginal & Torres Strait Islander students and graduates. Midwifery has already been successful in this and she would like to see that expand. She sees the Indigenous Health Major as a desirable stream.

With a history of research, in her case, a PhD (School of Medicine, University of Leeds) on 'The impact of choice of care on women's psychological health', she is a strong advocate of the need to promote research and, in economic terms, to re-focus on the postgraduate market. Meanwhile, she is pleased to see a strong 'undergraduate portfolio', especially in nursing & allied health disciplines such as Occupational Therapy both of which are "growing year-on-year."

On balance, and amidst global uncertainty, Julie Jomeen's timing has been perfect and the knowledge and enthusiasm she brings to our regional university will be a great asset. So will be the skills of the graduates and researchers, many of whom will remain here to nurture a growing, ageing and socio-economically disadvantaged population.

Theranostics is an innovative, personalised approach to cancer medicine that brings together therapy and diagnostics. It allows the doctor to combine a fast and accurate diagnosis with precisely targeted therapy.

Most evidence to date is in metastatic castrate resistant prostate cancer and advanced neuroendocrine tumours (NETs).

Theranostics is not suitable for all patients but may be an option in metastatic disease unresponsive to or unsuitable for conventional therapies.

How does it work in prostate cancer?

Treatment involves the injection of a radioactive drug which destroys prostate cancer cells throughout the body by delivering radiation in a highly targeted way. The radioactive drug used to treat prostate cancer is specifically designed to bond to PSMA (prostate specific membrane antigen) protein on prostate cancer cells. Most of the radioactivity that does not bind to tumour cells is rapidly excreted from the body following the procedure.

This targeting maximises radiation dose to the cancer while minimising chance of injury to other tissues. The presence of treatable PSMA proteins and cancer cells is confirmed using a PSMA PET/CT scan prior to treatment.

Access for patients is via the TGA Special Access Scheme.

Theranostics is provided to patients on the Gold Coast through a partnership between GenesisCare, Australia's largest provider of oncology services and South Coast Radiology, the leading imaging provider in South East Queensland.

Dr David Macfarlane
Nuclear Medicine Physician

John Flynn Private Hospital,
Nuclear Medicine & Therapy Centre
42 Inland Drive, Tugun QLD 4224

Contact us

Tel: 08 9438 8500 | Fax: 08 9438 8510
theranosticsreception@genesiscare.com

https://www.genesiscare.com/au/our-centres/south-coast-radiology/

SOUTH COAST RADIOLOGY

GenesisCare

Book Review

by Robin Osborne

The Undying

By Anne Boyer
Picador 308pp

Despite a title that sounds like a television zombie series, this Pulitzer Prize-winning account of an American writer's journey through cancer diagnosis, treatment and, ultimately, recovery is as real as could be imagined. It is also angry, witty, learned and well researched, drawing on sources as wide ranging as Susan Sontag's acclaimed Illness as Metaphor, the ancient Greeks and Romans, John Donne and John Cage, and, not surprisingly, Siddharta Mukherjee's classic history of cancer, **The Emperor of All Maladies.**

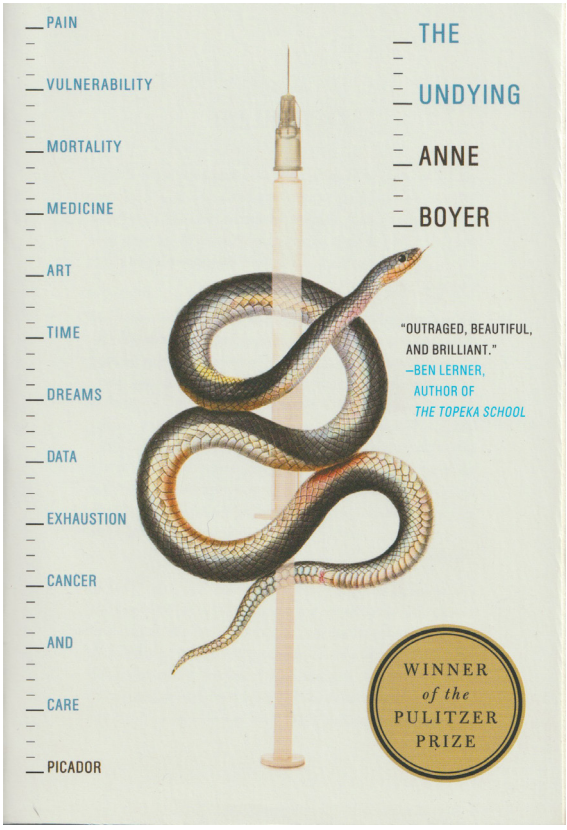
At the time of her diagnosis with triple negative breast cancer Boyer was a single mother, a poet and a part-time university lecturer. She would soon come to appreciate the financial and personal support of friends.

Delivering her the bad news an oncologist explained there were no targeted treatments for a cancer that had significantly poorer prognosis than other forms, and that she needed 'Neoadjuvant chemotherapy – "which meant right away.'"

To not submit to chemotherapy was to die, the doctor said, while "To submit to it, I thought, was to feel like dying but possibly to live, or to die from secondary effects rather than primary disease, or to live, finally almost restored but not quite."

So begins the patient's existential journey into cancer-land where "As soon as a patient lies down on the exam table, she had laid down her life on a bed of narrowed answers, but the questions are never sufficiently clear."

Confessing "I didn't know anything about having cancer" she notes that, "Before I got sick I was strong, but soon to be so weak that to walk short distances, like the six feet from the bed to the bedroom door left me winded.



"First a whole life of being appetitive, then to not be able to eat or have sex and to not want to... and all that time, too, in multifocal pain... Aristides begins his Sacred Tales with a declaration of the difficulties of writing about the experience of sickness..."

Comprised of short sections and sub-chapters, this memoir, erudite and immeasurably sad, can be consumed in a sitting, as I did, or in bite-size chunks of only a few sentences –

"In the waiting rooms, the labor of care meets the labor of data. Wives fill out their husbands' forms. Mothers fill out their children's. Sick women fill out their own."

Or,

"Every movie I watch now is a movie about an entire cast of people who seem to not have cancer, or at least this is, to me, its plot... people everywhere looking robust and eyelashed and as if they have appetites for dinner and solid plans for retirement."

Her description of treatment regimens provides a rare insight into a world that, mercifully, many will not enter.

The chemotherapy drug Adriamycin "is named for the Adriatic Sea, near which it was discovered. Its generic name is doxorubicin, a name derived from 'ruby' because it is a brilliant and voluptuous red.

"I like to think of this poison as the ruby of the Adriatic, where I have never been but would like to go, but it is also called 'the red devil' and sometimes it is called 'the red death', so maybe it should be called the satanic jewel of mortality on the shores of Venice, too."

As she explains, those administering the drug via a chest port must wear an "elaborate protective costume" as it destroys tissue if it escapes the veins and is rumoured, if spilled, to melt the linoleum on a clinic floor.

After a double mastectomy, a procedure, which, in the US at least, is handled as day surgery, Boyer returns home in pain, and due to inadequate sick leave must resume lecturing ten days later.

A few years on, relieved that the treatments had rendered her 'undying', she has produced a book that will inform and inspire a wide range of cancer patients, even if she was unable to write down all of "the great orbs of the unsaid [that] continue to float through the air."

It should be noted that she dismisses the many crank cures that came her way via the internet, including cannabis, alkaline water, fruit and vegetable juices, and other alternative 'treatments'.

In summary, she writes that, "Cancer kills people, as does treatment, as does lack of treatment, and what anyone believes or feels has nothing to do with it. I could hold every right idea, exhibit every virtue, do every good deed, and follow every institutional command and still die of breast cancer, or I could believe and do every wrong thing and still live."

Therein lies the cancer mystery that remains to be solved.

Currumbin Clinic welcomes two new Consultant Psychiatrists

Meet
Dr Paxie Olm

FRANZCP, Cert Addiction Psychiatry (Fellow in Training), MBBS (UQ), Bachelor of Science (USQ), Generalist Adult Psychiatrist in Private Practice on the Gold Coast.

Dr Olm has experience in the diagnosis and treatment of a broad range of mental health issues and is passionate about positive mental health outcomes for all Australians. She has developed a particular interest in preventative health and wellbeing, and addiction psychiatry but also enjoys all facets of psychiatry such as general depression, anxiety, borderline personality disorder and trauma related disorders.

She also has specialised training in psychotherapy and repetitive transcranial magnetic stimulation. She is a Member of the Faculty of Addiction Psychiatry and a Member of the Section of Electroconvulsive Therapy & Neurostimulation. Dr Olm is a registered Opiate Therapy Program (OTP) prescriber in Queensland. She finds it important to allow space for psychological therapies within her practice.

To arrange an appointment or referral, please phone Dr Olm's consulting suite on 5586 4950 or fax 5525 9686.

Meet
Dr Michael Lee

FRANZCP, MBBS (UQ), Bachelor of Science, Generalist Adult Psychiatrist in Private Practice on the Gold Coast.

Dr Michael Lee trained locally and has worked in a variety of treatment settings within Brisbane and on the Gold Coast.

He draws on experiences from public and private mental health services which include General Adult Psychiatry, Emergency Psychiatry, Drug and Alcohol Services and Liaison Psychiatry.

His advanced training focussed on Addiction Psychiatry including working as a registrar at Currumbin Clinic.

Dr Lee practices in a contemporary framework with a collaborative and non judgmental manner aiming to align with an individual's recovery goals while promoting their own resilience.

To arrange an appointment or referral, please phone Dr Lee's consulting suite on 5586 4950 or fax 5525 9686.

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Medical

Tapa designs take a lot of beating

Sihotie, Nioge: New from Old: Omie Tapa Art PNG, Lismore Regional Gallery until 28 March 2021.

The 'cloth' to produce tapa comes from the beaten bark of the paper mulberry tree, found and worked in many parts of the Pacific, including Hawaii and Tonga, and believed to have been brought from parts of China and Taiwan millennia ago.

The small catalogue for this stunning exhibition of painted tapa from the Omie people of PNG's Oro province comes with a swatch of the real thing, the earthy colours instantly pleasing to the eye. It explains that, "Many elements in tapa design are at once physical representations of their environment and part of esoteric knowledge known only to the Omie," adding, "The production of nioge tapa cloth is now one of the most important material elements of Omie cultural practices and plays a critical role in defining and maintaining Omie unique cultural identity."

The Omie are a remote people numbering around 2200 souls whose seven main villages perch on the slopes of the eastern coastal ranges. While stunning, this is an economically deprived part of a generally poor if extraordinarily artistic country. Papua New Guinea has a number of tapa making communities. To the foreign eye, their work is abstractedly geometric and highly appealing, with the colours, like the beaten 'cloth', being drawn from nature, and the symbolism, like much Aboriginal art, revealed only by explanation.

The skills of the Omie are a standout but only in comparatively recent times have they been recognised by the wider world. Working with locals, the driving force behind this expansion was an Australian Joan Winter who has supported the mostly-female artists to understand and access the Indigenous art market and helped mount overseas exhibitions such as this one. The works are on sale but do not come cheap, nor should they - there is no doubt that the income provided will be appreciated back home.

NEUROCARE

Dr. Swapna Sebastian MBBS, MD (General Medicine), MRCP (UK), FRACP

Dr Swapna Sebastian is a Neurologist at John Flynn Private Hospital, on the Gold Coast, who is now **consulting in Lismore twice a month and Grafton once a month.** She will also be running an **EEG service in Lismore.**

Dr Sebastian completed neurology training with the Royal Brisbane, Princess Alexandra and Gold Coast Hospitals. She trained in epilepsy at the Royal Brisbane and Epilepsy remains her main area of interest. She also has a keen interest in Multiple Sclerosis, headache and peripheral nerve disorders. She is a member of the RACP (Royal Australasian College of Physicians), ANZAN (Australian and New Zealand Association of Neurologists) and the RCP (Royal College of Physicians, UK).

Outpatient services include:

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- Botulinum toxin (BOTOX) for Chronic Migraine, Cervical Dystonia, Hemifacial Spasm, Blepharospasm and Primary Axillary Hyperhidrosis.

The Lismore Clinic is located within Northern Rivers Cardiovascular Clinic – 90 Diadem Street, Lismore.
The Grafton Clinic is located within Happy Smiles Dental – King Street Arcade, Grafton.
Bookings can be made by calling Neurocare on (07) 5598 0908.
Referrals can be sent via Medical Objects, emailed to info@neurocarecentre.com.au or faxed to (07) 5598 0905.
A PDF of the referral form is available at **www.neurocarecentre.com.au**

Allied Health on the North Coast

Authors: Mr Rob Curry, Executive Officer, NCAHA, Associate Professor Jacqui Yoxall, Chairperson, NCAHA and Dr Susan Nancarrow, Director, NCAHA

Introduction

In Australia today Australian Health Practitioner Regulation Agency (AHPRA) registration and survey information reveals there are over 600,000 registered health professionals delivering services in communities across the country – approximately 345,000 nurses and midwives; 101,000 medical practitioners; and 21,000 dentists (Australian Government, 2019).

There are also over 150,000 registered allied health professionals (AHPs) delivering a wide scope of services across health, education and community sectors. In addition, there are an unknown number of allied health practitioners from unregulated professions (e.g. dietetics/ nutrition, speech therapy) that would take the national AHP figure up around 200,000.

Although we do not have accurate local workforce data, it can be estimated there are 3,000 – 4,000 allied health professionals qualified to practice on the NSW North Coast. Previous work by the North Coast Primary Health Network (in 2017) noted that at least 2,500 AHPs working in the region, a high percentage in private practices. However, this is likely to be a conservative estimate.

These figures indicate that AHPs represent a significant component of the health workforce in our region. The large numbers of AHP businesses and NGOs providing services in the primary care sector are also significant. It therefore stands to reason that the overall engagement of AHPs with the general practice sector needs to be of high quality and efficient, given the centrality of GPs to primary care in the Australian context. Although there are clearly many excellent relationships between individual AHP businesses and GP practices across the region, and these synergies are producing high quality engagement for integrated care, there would appear to be more general barriers to optimal communication that need to be looked at and resolved. This article focuses on these issues.

Allied Health Vision for the North Coast

The vision of the North Coast Allied Health Association for the North Coast community is based on the following core aspirations:

Integrated Multi-disciplinary Care: North Coast health services are well-integrated in order to provide effective, multi-disciplinary and cross sector responses to meet the needs of regional communities.

- **Patient-centred Care:** All health services are patient-centred and prioritise the issues and needs of patients over professional needs (this is not to discount professional needs).
- **Agreed Clinical Pathways:** There are clear clinical and service pathways for North Coast health service consumers based on agreed best practice for a multi-disciplinary and multi-sector primary care environment.
- **Prioritising unmet needs:** Unmet needs for health services within the broader community and for particular North Coast communities are clearly identified and prioritised for action by health agencies and managements across the region.
- **Team-based professional development:** Along with discipline-specific professional development, multi-disciplinary team-based professional development for providers on the North Coast is focused on matching the identified priority challenges in health care.
- **Collaborative planning and research:** There are many and varied opportunities for collaboration across the health care professions and with the public in order to undertake health planning and research attuned to the needs of the North Coast community.

Current barriers to Integrated, Patient-centred Primary Care

The current state of play with each of these aspirational elements for best healthcare is mixed.

Integrated multi-disciplinary care remains a fundamental challenge. Health care on the North Coast continues to be plagued by many of the health disciplines continuing to work in relative isolation from each other, often on the basis of different funding sources and management structures for the conduct of their health practice.

This is not patient-centred care. Patient-centred care would require that professional and sector barriers be significantly addressed to produce coherent and connected health care, particularly for those with complex or chronic conditions.

One area of particular concern for AHPs has been the limited inclusion of allied health in the development of the My Health Record system – how can we have effective integrated care when health professionals cannot efficiently and effectively communicate with each other regarding their shared clients?

This basic shortcoming must be sheeted home to the Commonwealth, which has ultimate responsibility to the population for the whole of the Australian healthcare system. Simply put, it has not effectively embraced its responsibilities to the allied health components of that system.

As discussed above, ambitions for patient-centred care are compromised on the North Coast. Although individual practices and practitioners may adopt patient-centred approaches as best they can with a high degree of care and concern for their patients, the system as a whole is not conducive to building its services around the consumer.

Regarding best-practice clinical and healthcare pathways, significant work has been done by NSW Health in defining and implementing such pathways, and by the general practice sector for elaborating

Allied Health professional relationships with General Practice on the North Coast Paper

such pathways for GPs. However, not enough has been done on the North Coast, or nationally, to determine best pathways for multi-disciplinary health teams working in integrated primary health care, or for transition between hospital and community settings.

Patient-centred care requires that effective health services and providers are sensibly arrayed around the complex needs of clients, not to suit particular professional interests and convenience. Clinical pathways have been elaborated elsewhere for various allied health professions, but the challenge for health providers – allied health, medical and nursing – is to work out how we can all work best together for the client, and to define and implement these team-based pathways.

To our collective discomfort, there are significant unmet needs for health services in particular North Coast communities. Deficits are seen in the health response for Aboriginal communities where, as obvious examples, the rates of low birth weight, infant mortality and renal failure in Indigenous adults remain unacceptably high (HealthStats NSW).

No one could suggest that solutions to these health challenges are straight-forward, but nor could it be claimed that the health sector is performing adequately to resolve them. With particular reference to needs related to allied health care, our Association is aware of limited access to AHPs for people who choose health care in Aboriginal community-controlled health services, or lack capacity to pay for services.

A further example in the broader community is a lack of community-based rehabilitation services for stroke or head injury sufferers once they have completed their acute rehabilitation programs. People who lack financial resources are unable to purchase these services - despite there being adequate numbers of private AHP providers in the region - and as a result they are achieving sub-optimal rehabilitation outcomes at great cost to themselves and the community.

In recent years, efforts have been made to improve the development and provision of multidisciplinary professional development (PD) to support team-based approaches. Healthy North Coast (i.e. the North Coast Primary Health Network) ensures that many of its PD offerings cater for a multi-disciplinary audience, and much training offered by the Local Health Districts is multidisciplinary in nature.

> "Health care on the North Coast continues to be plagued by many of the health disciplines continuing to work in relative isolation from each other…"

However, the range and quality of the training requires a focus of attention and far greater collaboration between North Coast health agencies to ensure our health teams are working together efficiently with the patient at the centre of their attention.

We do note the recent demise of the Cape Institute – its efforts to provide multi-disciplinary training and to meet allied health PD needs were on point.

Given that each health discipline brings unique skills and expertise to bear on a patient's health situation, and given that most of our clients require the skills of at least two or more health professions for optimal care, then it follows that healthcare planning and research endeavours on the North Coast should often be multi-professional in nature.

This not to deny the need for discipline-specific planning and projects, nor that there is not multidisciplinary activity already being undertaken. However, a positive future will have, as a basis, far greater professional collaboration, investigation and innovation in the health field. In this regard, the University Centre for Rural Health on the North Coast, and the university resources across the whole North Coast footprint, will have a key role to play.

Stakeholder Benefits from Health Care Improvements

With progressive action in each of the aspirational elements described above, a range of stakeholders are likely to benefit. With greater emphasis on multi-disciplinary care, clearer team-based clinical pathways, team-based professional development opportunities, and collaborative health planning and research, we are likely to see improved recruitment of AHPs to the region and more substantive AHP workforce retention and career development.

Consequently, we would anticipate closer and more productive engagement between AHPs and GPs in the world of primary care, as each professional group develops more knowledge of the other, and more confidence to work together for better health care.

Finally, and most importantly, the community is likely to benefit from a stronger, more engaged and collaborative workforce, focused on patient-centred practice and addressing unmet needs, and being supported by clearer health planning and agreed team-based approaches.

The Australian Government and Allied Health

In laying out these ambitions for better health care on the North Coast, albeit through an allied health lens, it is important to note that some improvements can be mediated specifically on the North Coast, but others will require policy changes at the national level to facilitate positive impact in the regions.

The North Coast Allied Health Association believes that the Australian Government is not currently, and has not historically, fulfilled its obligation to Australians in terms of the fair and equitable provision of allied health services. To be clear, the Australian Government has ultimate responsibility for the whole of the healthcare system. If it cannot provide, or directly ensure, the necessary services to meet community needs, it must contract state and territory governments or other providers, such as GPs or NGOs, to provide these services.

Although Commonwealth Health funds the jurisdictions to provide a range of necessary allied health services, particularly in hospital settings, it provides very little assistance to private allied health providers to deliver their services (as is provided to GPs). As a consequence, private AHP businesses do best in metropolitan locations where there are

Rising vaccine hesitancy needs urgent addressing

by Alannah Mann,
Northern Rivers pharmacist

With the rollout of COVID-19 vaccines commencing over the next few months in Australia, addressing vaccine hesitancy will prove challenging for all health care workers. Achieving an adequate level of herd immunity and protecting those most vulnerable in the community depends not only on adequate COVID-19 vaccine supplies, but on a high level of vaccine support and uptake.

In comparison to other countries such as the USA and France, Australia is considered to have a low level of COVID-19 vaccination refusal[1]. In June 2020, an online survey of nearly 5000 Australians aged 18 years and over found that 4.9% would not get the COVID-19 vaccine, 9% reported an indifference to a COVID-19 vaccine and 86% said they would get a vaccine if it became available.

This survey was conducted during April 2020, when Australians were in the midst of lockdowns and the fear of serious COVID-19 outbreaks and disease was high amongst community members[2].

A few months later, another online survey of Australian parents (n=2018) during June 2020 showed that 75% of respondents said they would be vaccinated against COVID-19, 17% were unsure and 8% were unwilling to get COVID-19 vaccinations[1]. Thus, vaccines hesitancy increased by approximately 10% during the period from April 2020 to June 2020 and this may be partially explained by the relaxation of lockdowns and the perceived lower risk of COVID-19 disease amongst the community.

Of those parents who were unsure or unwilling to accept the COVID-19 vaccine, 83% were concerned about vaccine efficacy and safety and 27% believed that vaccination against COVID-19 was unnecessary[1]. Research by Dror et al suggests that most safety concerns are around quality control, particularly associated with the speed of development, as well as side effects[3].

These surveys showed that patients were more likely to display vaccine hesitancy if they had lower levels of education, had poor health literacy, and were younger than sixty years of age[1, 2]. Other research suggests that COVID-19 vaccine hesitancy is more likely amongst females, those with populist views, those who felt that COVID-19 was overstated and those who are highly religious[4].

Vaccine hesitancy has been also observed amongst many health professionals, though it is less frequently observed when healthcare workers have been involved in the care of patients with COVID-19[3]. Both health care workers and community members have expressed even greater vaccine hesitancy regarding vaccination of children[3]. Perhaps unsurprisingly, annual influenza vaccination is a strong predictor of acceptance of a COVID-19 vaccine[3].

Effectively communicating and building trust with our patients is vital to reducing vaccine hesitancy. All health care workers should ensure they are adequately educated and able to provide support regarding COVID-19 vaccines. This is crucial so that healthcare workers are confident about these vaccines and are able to adequately address vaccine concerns[5]. Additionally, early public health education campaigns are an important part of the approach to reducing vaccine hesitancy as they may reduce COVID-19 vaccine fear[3].

This public health information should be appropriate for people from diverse cultural and linguistic backgrounds, Indigenous populations, and those from a low health literacy or education population[5]. Other effective ways to reduce vaccine hesitancy include messaging delivered by trusted members of the community, such as community or religious leaders[4]. We must all play our part in educating and informing the general public, aiming to minimise vaccine hesitancy wherever possible.

References on website

Allied Health on the North Coast

sufficient people with capacity to pay. They do far less well in regional and rural areas, such as parts of the North Coast, where establishing and maintaining a viable health business becomes progressively more challenging, until we get to remote areas where allied health businesses are virtually non-existent, and allied health services essentially unavailable.

Despite recent positive developments with the appointment of the National Rural Health Commissioner, his report on the Rural Allied Health Workforce, and the creation of the Chief Allied Health Officer in the Health Department (albeit part-time), the Commonwealth must reconsider its view of allied health within the broader health system, and accordingly set up structures to ensure Australians get the services they need to maintain their health and keep them out of hospital.

Conclusion

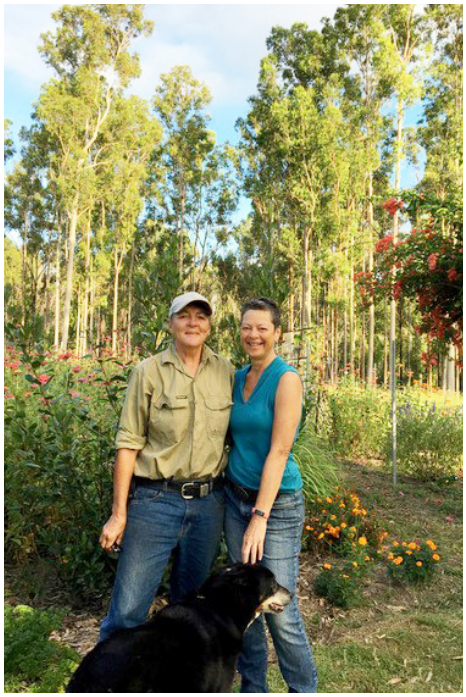
There are great opportunities to build stronger relationships between our professions in this region. AHPs understand the importance and enormous benefits for themselves and for patient care that could accrue from enhanced multi-disciplinary practice, particularly with reference to people with complex or chronic conditions. To a significant extent, both of our professions are being held back by policy and systems that have been beyond our control, and by historical precedent, which gets in the way of genuine efforts at integrated care and patient-centred approaches. But there are exciting possibilities for us to explore in our local region.

The jumble of recovery

Hayley Katzen writes of the impacts of cancer and bushfire, and the long recovery process from both.

I empty the rain gauge of its 160 ml and walk back to the house, my pink gumboots sloshing through puddles. It's a year and two months since the Long Gully Bushfire stormed our area on 8 October 2019. Today the bush around our house is a blur of black and green, breathtakingly beautiful.

In amongst the sculptural black dead wood are trunks coated with a fuzz of green, some again bear a canopy. Many of the spotted gums have followed their usual cycle and lost their bark, some are light emerald green, some orange. But for others, burned bark still clings to their trunks, red sap weeps from wounds. Even those that stand tall and proud, now have ruts etched into their trunks. Scars.



My partner Jen's garden is a sea of gold this year – nasturtiums, cosmos, marigolds and sunflowers – dotted with cornflowers and sprays of tiny cottage mix flowers. Soul food, Jen calls her flower garden. It's how she processes grief – life, I suppose. Over these last decades, I - who lack the gardener's disposition - have been a grateful and wide-eyed beneficiary of her flower gardens.

Today, the tall sunflowers nod limply, heavy with water.

A wilted sunflower. That's how I looked according to my GP when in late February 2019 I saw her about unusual exhaustion, and digestive problems. Thankfully she ordered a wide range of blood tests. Some three weeks later the diagnosis was confirmed in a Gold Coast Hospital: Stage 3C Ovarian Cancer that had metastasized to the peritoneum. After nine weeks of chemo, the surgeon was able to operate. He removed cancer from 17 places inside me. I learned the names of body parts because I'd lost them. I was lucky it was operable.

I was lucky again on Tuesday 8 October 2019, the day that Long Gully Bushfire stormed our area. Unlike the two locals who died. Unlike my neighbour who lost his grand design of a house.

Jen and I were home that Tuesday. We saved the house – if not the outbuildings, the drought hay for our cattle, water infrastructure and fences. If the fire had struck on the Wednesday we'd have been 125 km away in Lismore where I was having chemotherapy. Lucky.

Five weeks after that fire, in late November, despite the losses and exhaustion, the shocking changes to lives and landscape, the black talcum powder and dust underfoot, the still smoky air, our small community held 'Ewingar Rising', a three-day bushfire benefit recovery concert. It raised our spirits – and together with associated fundraising drives, $78,000. As Anne Leadbeater from Kinglake so aptly said when she visited our community hall after the fires, "droughts isolate and bushfires galvanise communities."

But natural disasters – including cancer - seem to have three distinct phases. First there's the emergency, then the response and then the recovery.

These days the word 'Recovery' is everywhere: there's a National Bushfire Recovery Agency, federal and state government Disaster Recovery Grants and a myriad of non-governmental recovery grants. Funds to help people rebuild homes and businesses, even funds to strengthen communities and rebuild well-being – if you can navigate the paperwork.

I'm intrigued by the meaning and process of 'recovery'. For my bushfire-affected community. For the bush. For myself.

Three months after the fire we had a small flood. Trees sent out epicormic shoots, bright pinks and greens sprouted from black ironbarks, lurid neon green

sprouted from grass trees, and in our garden weeds and grass and wild zinnias bloomed. My body too was sprouting: again hair covered my scalp, I had eyelashes and patchy eyebrows. Like the music festival, the new growth in the bush and of my body was invigorating and exciting. Joyful. Everywhere and all at once, amongst the burn, there was blooming.

As the country went into lockdown over COVID-19, Jen and I sat on the front veranda. "Can we keep those burned bits on the bay tree," I asked, "for just a bit longer?"

The bay tree, just a metre from our house, was two-toned, a balloon of crunchy brown leaves and a few wands of deep green new growth sprouted from the base.

Jen laughed. "What? There aren't enough burnt trees around?"

I insisted. The two-tones were comforting; they reminded me of change and transformation, of possibility.

It's fifteen months since that fire, and seven months since a second surgery in June 2020 removed another tumour. Again, I was lucky; again I'm 'all clear for now'. So very grateful. Now we 'watch and wait' with tests every three months.

'Recovery' has come to seem like an ongoing, seemingly endless, process. It is so very different from that initial invigorating and exciting 'response' to the 'disaster'. As I've sought to re-establish a life free of cancer treatment, as we - and our neighbours - have cleaned up and sought to re-establish our homes and farms, our community has rarely gathered, other than for fire brigade meetings.

Perhaps like droughts, recovery leads to isolation, particularly during a pandemic. Certainly, recovery is quieter and more

Benefits of eReferrals becoming clear

by Timothy Marsh,
Northern NSW LHD

A pilot project testing electronic referrals (eReferrals) from general practices to outpatient services in Lismore is reaping benefits for both the Northern NSW Local Health District (NNSWLHD) and primary care providers.

The pilot began in June 2020 with two key goals in mind – to determine if GPs would take up eReferrals as a secure alternative to faxing and to ensure there were no safety or operational issues for either GPs or the LHD clinics.

In the interests of simplicity and expediency NNSW LHD implemented a generic referral form for GPs using HealthLink Forms. HealthLink Forms is the same system used for Transport NSW certificates and Commonwealth My Aged Care referrals and integrates into the major GP clinical software systems.

A basic referral management system was set up to receive eReferrals in the LHD and, importantly, to let LHD operators send electronic status updates back to GPs as the referral moved through the NNSW LHD service.

Initially commencing with the Lismore Base Hospital Specialty Outpatient Clinics and Lismore Pain Clinic, the project has since added additional services:

- Knee and Hip Arthritis Service Lismore
- High Risk Foot Service Lismore
- Integrated Aboriginal Chronic Care (IACC – all of NNSW LHD)
- Sexual Health Service (covering the Clarence, Richmond and Tweed-Byron areas)

After just seven months of the trial, NNSW LHD Project Lead, Tim Marsh, said the willingness of local practices to adopt the new system had been encouraging.

"Although GPs have long been asking for a better alternative to faxing we had no idea what the uptake would be like when we finally introduced a new system," Mr Marsh said.

"We have been surprised and pleased at the fast and widespread uptake by GPs.

"Looking at other similar projects around Australia as a guide, we anticipated that it might take over 12 months to reach our goal of 1000 eReferrals, especially given the small number of services involved in the pilot.

"However, we are on track to hit this target two-three months earlier, which is surprising but gratifying for everyone involved."

The pilot program involves closely monitoring key metrics over time such as volumes by LHD service, GP clinic and GP. This helps paint a picture of present demand, and will lead to better forecasting for the future.

As of early February 2021, 109 GPs from 32 practices have used eReferrals, with 73% of GPs sending more than one eReferral, and 61% of GPs sending more than four eReferrals (four being the median number of eReferrals per GP).

"The eReferral system has provided a level of insight we've not had before. It has helped to identify issues that can arise during the referral process, such as difficulties contacting patients via phone, which we believe eReferrals will help solve."

The pilot has also revealed that using eReferrals can save a substantial amount of administration time for staff, with savings of around 10-40% in referral handling time compared to using fax.

"Staff are saving time by not having to sort faxes, obtain additional information from GP surgeries, or compose paper-based letters back to GPs advising of appointment times and triage outcomes. This frees up more time to engage with patients," Mr Marsh said.

"Instead, the LHD can now let GPs know about appointment times electronically, reducing the time needed for this task by 57%."

The qualitative evaluation is commencing soon and will be seeking feedback from GPs' practice managers and LHD administration, clinic managers and specialists to assess the impact of eReferrals on their workload and practices.

The evaluation will also help inform future expansion of eReferrals into other locations across the NNSW LHD.

The jumble of recovery

private, devoid of the drama, the energy and tangible changes evident during the other phases. It may seem 'inspiring' to outsiders and sometimes it is indeed invigorating but mostly it's slow and tedious, messy and confronting, chaotic and bewildering.

Finally, new branches grew from the base of the bay laurel, some weepy, some upright. Fresh and strong with the suppleness of new life, they were overtaking the dead wood. I realised the dead wood had begun to seem an insult, as if my personal tangible reminder of possibility might be harming the tree. So in December, slowly, awkwardly, carefully, I pruned the dead wood and its dried leaves.

I feel a tad responsible for how the bay laurel has grown, a little embarrassed I let it get to this. Just as I'm sometimes embarrassed and disappointed by my body – that I get so tired still, that symptoms send my mind wondering if the cancer might be back again, that I'm unsure where to focus my energy given my body's new constraints and ovarian cancer's reputation for recurrence.

Despite the uncertainties for my body and this bushfire-prone landscape and community, my heart lifts when I walk amongst ironbarks that again have silver leaves and spotted gums bare of bark. In the background is the soundtrack of my neighbour's generator as he builds himself another somewhere to live.

The trees are my soul food, reminding me of change, of seeds and new growth, of cycles and seasons. Like the bay laurel's jumble of dead stumps and new branches, recovery – or perhaps life itself – is patchy and chaotic with a rhythm of its own.

Hayley Katzen's essays have been published in Australian and overseas journals and anthologies. A review of her memoir Untethered appeared in NorDocs Summer 2020-21 issue.

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Dr Sarah McGahan MBBS FRCPA
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(02) 6620 1203

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.

Dr Patrick van der Hoeven MD FRCPC FRCPA
patrick_vanderhoeven@snp.com.au
(02) 6620 1202

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. Dr van der Hoeven joined SNP in 2019.

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Sullivan Nicolaides PATHOLOGY

UOW regional vocational training

2021 has seen one of the largest cohorts of medical registrars in the Clarence Valley.

During the past three years, University of Wollongong Clarence Valley Regional Training Hub (CVRTH) has worked with Clarence Health Service and GP practices to increase vocational training opportunities in our region. The hope now is to continue to recruit, train and hopefully retain clinicians to Grafton, helping to build a larger medical workforce to support our community.

medical registrars, the Clarence Valley also has GP registrars continuing their training in practices across Grafton, Maclean and Yamba. Four of these GP registrars are through the Australian General Practice Training program (AGPT) and two have been recruited through the RACGP Practice Experience Program. The Clarence Valley presently has six GP registrars training and living locally in 2021, the most we have seen in many years.

The eleven medical registrars are looking to stay in the region long-term, identifying Grafton as a place where they can, not only grow their medical careers, but also raise their families.

Photo above L-R: Grafton Base Hospital 2021 Registrar cohort - Drs Sherng Lee, Anselm-Zixton Ogbujieze, Annmarie Winters, Mitch Van Deurse, Melinda Swan. Photo credit Clarence Valley Independent.

The additional training places has enabled Clarence Health Service to recruit medical registrars this year who are completing specialty training across a number of vocational pathways. Grafton Hospital has a Rural Generalist Paediatric Advanced Skills Registrar, GP Proceduralist in Emergency Medicine and two Emergency Medicine Registrars through Australian College for Emergency Medicine, each completing 12 months training.

In addition to the five hospital-based

Many of the new faces in the hospital are from the big cities, with this being their first time working and living in a regional area, whereas others have spent over a decade in regional parts of the country. They all hope to serve the community to the best of their ability.

by Joanne Chad
Program Coordinator, UOW

UNIVERSITY OF WOLLONGONG AUSTRALIA

It wasn't until University of Wollongong Alumni **Dr David Glendinning** was well into his first career as an engineer that he had a change of heart. He decided to try medicine. By that time married life had taken hold, but a 12 month placement in Lismore as a UOW medical student became a more permanent fixture as David finally settled into general practice there.

He may have been late to the party but David Glendinning has made some wise decisions in life – first to choose medicine, and then to choose a regional setting in which to practise at Goonellabah Medical Centre.

David's journey reflects the foundation of the UOW medical program where a student is placed for 12 months with a GP preceptor, in David's case Dr Andrew Binns at Goonellabah Medical Centre, participating in an integrated longitudinal rural placements which are designed to promote favourable student attitudes towards and facilitate return to rural practice upon graduation.

David's journey into medicine can be heard through the Destination Medicine podcast series:

https://www.destinationmedicine.com.au/podcasts/a-late-starter-to-medicine-finds-all-round-fulfilment-as-a-lismore-gp/17

People with disabilities and the Covid-19 pandemic

by Dr Dinesh Palipana

The Disability Royal Commission has been an excellent instrument to explore challenges in disability within Australian society. It is a protected environment for all Australians to speak about their experiences openly.

During the COVID-19 pandemic, many issues affecting Australians with disabilities surfaced. For example, we tackled questions regarding healthcare rationing affecting people with disabilities. In Australia, we have been lucky to avoid the situations that other countries have faced. Around the world, some nations have taken the approach of treating people with disabilities to detriment when they require life-saving care. I am proud to say that Australia has taken a different approach. In addition to equitable policies, we have protected people with disabilities from contracting the virus at all. We have achieved this together, as a community.

Agencies around the country came together too. It was heartening to see the National Disability Insurance Scheme working with supermarkets to enable priority food delivery to people with disabilities. We witnessed roundtables on federal and state levels that engaged people with disabilities to ensure that their needs are met as far as possible.

Healthcare nonetheless remains a generally challenging thing for people with disabilities. Organisations like Spinal Life Australia and Check Up Australia are doing work to bridge the primary care gap. Even still, some hospitals have challenges like limitations in physical access to their facilities. Rural Australians with disabilities can experience much more hardship than their metropolitan counterparts. For them, even access to daily caregivers can be challenging. Charging their electric wheelchairs in the rural areas can be tricky. These are issues that many of us do not even think about. Considering the connection to land our rural Australians have, it is important to enable them to live where their heart is.

The requirement for daily caregivers broadly was complicated during COVID-19. What if a person with a significant disability needed to isolate? There are few options for them apart from coming into a hospital. Similarly, what if a person's caregiving team was asked to isolate? One can suddenly be left without familiar care. These are problematic scenarios for people who have caregivers well-acquainted in their complex day-to-day needs. Some people chose to isolate during the height of the pandemic with their entire care team. However, this is not an option for many.

Education and employment also remains challenging for people with disabilities. I navigated some of these issues myself in the journey of becoming a doctor. Although I've been lucky, I am sad to see how many people struggle to become educated or employed because of their disability. I am also sad to see the cruelty that some of them experience. While a large part of our society is supportive, there are pockets of resistance to enabling inclusion. For this reason, a groundswell of support from the community is important. If we see something that is wrong, it is important to speak out.

There are many issues that both the Royal Commission and we as a society have rapidly dealt with over the last year. However, we must maintain the momentum and continue to make a difference in these areas. For some problems, there are no easy answers. However, our country has the heart, strength and all the tools to become a beacon for our counterparts around the world.

The Year that Made Me: Dinesh Palipana, 2010

Dr Dinesh Palipana OAM was Queensland state recipient of Australian of the Year 2021. A doctor, lawyer and disability advocate, he is the second person with quadriplegia to graduate as a doctor in Australia and the first with spinal cord injury.

NorDocks Northern Rivers Doctors Network

Important dates

Northern Rivers Doctors Network

Webinars 2021

17th March

14th April

19th May

16th June

Thomas Noble & Russell

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