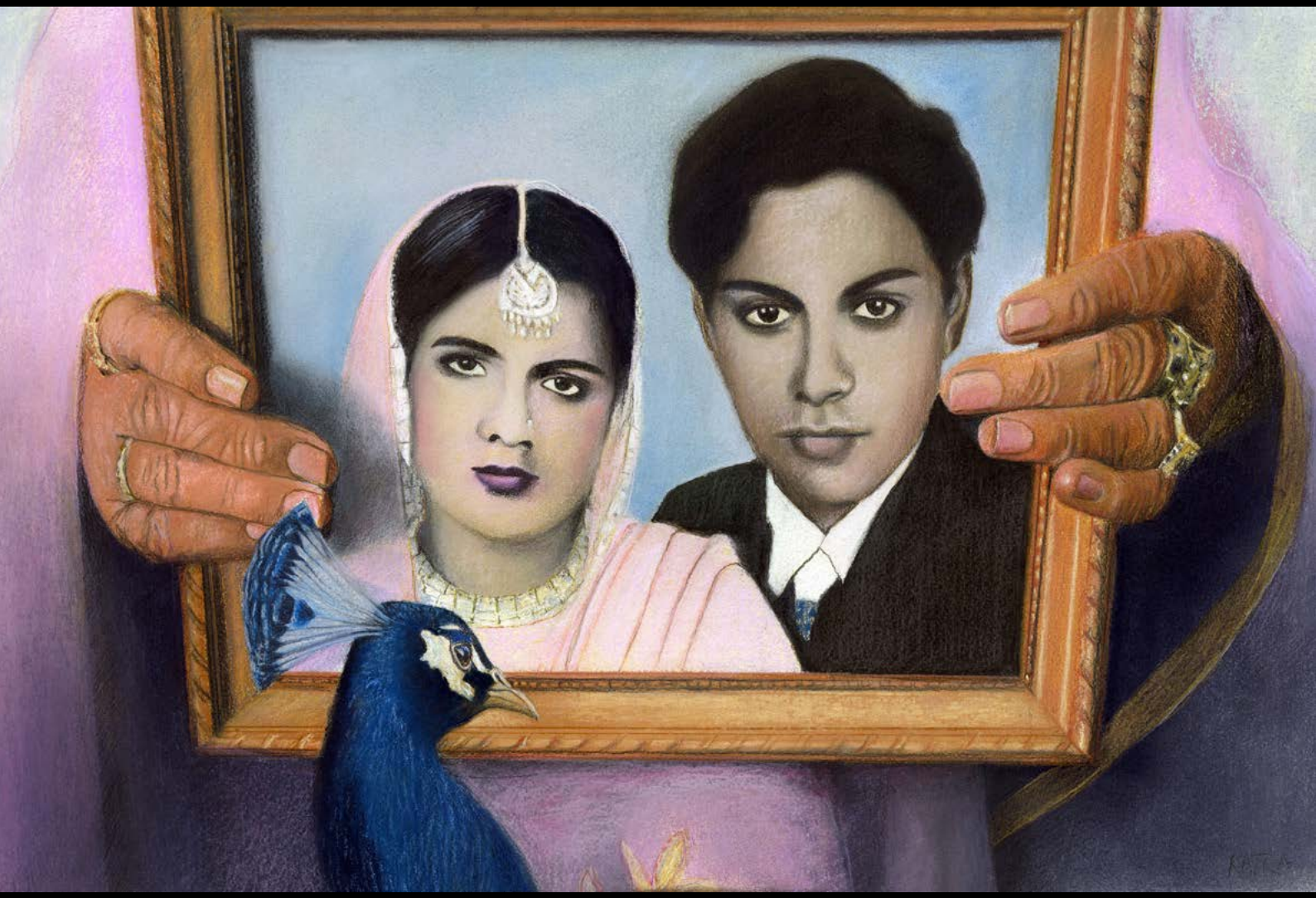
GP*Speak*

Winter 2019



- Coming Home - migrant faces of Lismore
- NORDOCS ‘unconference’ 2019
- ICE wind blows through
- Sleep health studied

North Coast Health Matters

GPSpeak

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IN THIS ISSUE

Love 2019, pastel and pencil on paper.

Image provided by artist, **Katka Adams**

Helen Dhnaram

b. 1943, Hussipan, Punjab, India

Born when Britain still ruled India, Raj-Rani Chand was one of eight siblings in a farming family. It was arranged for her to marry Jimmy Dhnaram, the 16-year-old son of Indian immigrants on the NSW North Coast.

"*The first time I saw Jimmy I really loved him.*"

In a double-wedding, Raj-Rani and her sister married him and his brother. The portrait shows her holding a photo of the young couple. She was only 13, unable to travel legally… so her father changed her birth certificate. She arrived alone, aged 15, and under the "good Australian name" of Helen joined her husband in a railwayman's cottage near Grafton.

In 1979, after running a shop in Casino, they bought Lismore's Winsome Hotel – "I'd never set foot in a pub before". They ran it for nearly a decade, then moved to Maryborough, Qld and ran another hotel.

Helen has seven children, 13 grandchildren and four great-grandchildren. She lost two babies.

The love of her life died in 2011 but memories of him and faraway India remain close to Helen's heart. She tends an abundant garden and in mango season the aroma of her pickles and chutneys wafts across Goonellabah.

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Editorial Winter 2019

Our cover this month is the painting "Love 2019" by local artist Katka Adams. Katka has explored the refugee experience in her recent exhibition "Coming Home". She describes her inspiration and motivations below and on Page 15 editor, Robin Osborne details her journey of escaping the Soviet crushing of the Prague Spring in 1968 and the start of a new life in Australia as "that Czech girl".

Dislocation from one's cultural roots is a common experience for many Australians from European, African and even Aboriginal backgrounds. For some art gives voice to their experience, for others it is the written word. On Page 14 local playwright, Janis Balodis, writes of his own dislocation as the inspiration for many of his works. At different times of his life he has felt either Latvian or Australian, or neither or both.

Light as art is a new aesthetic. The recently redeveloped Lismore Quad has brought this medium to the North Coast. On page 31 Bundjalung elder, Aunty Irene Harrington uses this dramatic canvas to remind us that many Aboriginal people in the latter half of the twentieth century lost their culture heritage while remaining on their own land.

On 1 June, the first day of Winter 2019, forty clinicians gathered at the University Centre for Rural Health's Lismore HQ for the Second Nordocs meeting. Once again the major part of the day was devoted to allowing the participants to speak on a topic they felt was of significance to them or to the region.

The "Unconference" format encourages participants to raise issues that are not deemed of significance by health authorities or which do not emerge in community surveys or needs assessments. Often only those deeply involved in an area can see alternatives or better solutions to the problems they confront every day.

As Henry Ford reportedly said, "If I had asked people what they wanted, they would have said faster horses."

The format differed from the previous year in that the day commenced with a plenary session by researcher and physician, Dr Nick Zdenkoski, speaking on Shared Decision Making with particular reference to the treatment of breast cancer.

The day also differed by concluding with a lively panel session on the issue of whether to call it a "Discharge Summary or Same Day Handover". Associate Professor Kat McLean has written extensively in the Australian medical press on the need for better communication between general practice and the hospital at the time of the transfer of care.

Kat was joined by local GP, Tony Lembke and Director of Medical Services Richmond Cluster, Katherine Willis-Sullivan who gave perspectives on the problem from the viewpoints of primary and secondary care. Also on the panel to give a close up view of the coalface was Dr Sabine Ringkowski who has worked as a junior medical officer in Germany and more recently in the Northern Rivers and Sydney. Our full report on the day appears on page 8.

We are most grateful to the UCRH for providing their venue, and to Northern NSW Local Health District and the North Coast Primary Health Network for their sponsorship support.

The social determinants of health (SDoH) are increasingly recognised as playing a significant role in chronic illness. These determinants can affect a person's health prior to conception right through to death, and has continuing ramifications thereafter.

The issues often seem insurmountable to GPs but Dr Andrew Binns has co-authored a book on addressing the issue. He also presented at the Nordocs Unconference and gave some practical examples of how to cut through with some patients in desperate need of help. His report on addressing the subject is on page 5.

While those from disadvantaged backgrounds are at a greater risk of drug abuse, it can affect people from all walks of life. Somewhat surprisingly the use of crystal methamphetamine is higher in regional NSW than Sydney. The Special Commission of Inquiry into the Drug "Ice" convened in Lismore in late May, as reported by editor, Robin Osborne on page 20.

Many medical practitioners presented before Commissioner Professor Dan Howard, including local D&A service providers Drs David Helliwell and Bronwyn Hudson. The recently elected member for Lismore, Ms Janelle Saffin, also tendered evidence, arguing for increased rehabilitation services particularly for those members of the Aboriginal community,

After four years the Medical Benefits Scheme Review is drawing to a close. The Review has been driven by internationally known researcher and clinician Professor

Bruce Robinson, former Dean of the University of Sydney, Medical School.

Medicine has changed a lot in the 35 years since Medicare was first launched. Stents and statins, laparoscopies and robotics, CT scans and MRIs are routine. Cancers can be prevented through vaccination, cataract removal requiring a two week hospital stay in the seventies is now performed with the placement of an intra-ocular lens resulting in improved vision within a few hours.

It is hard to think of an area of medicine where there have not been significant improvements, yet the remuneration structure through Medicare has remained largely unchanged over this period. On page 17 we delve into the Robinson review, its rationale and processes, and touch on some of its recommendations.

Making changes to a National Health Insurance scheme is fraught and there have been several failed attempts in Australia in the past. While doctors have been accused of "feathering their own nests", the lived experience of medical practitioners going through the six year winter of the Medicare freeze makes them deeply cynical of the government's motives.

While change might be needed it is hard to implement as Niccolo Machiavelli noted five centuries ago.

> *"It must be considered that there is nothing more difficult to carry out nor more doubtful of success nor more dangerous to handle than to initiate a new order of things; for the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order; this lukewarmness arising partly from the incredulity of mankind who does not truly believe in anything new until they actually have experience of it."*

cont on P4

Editorial

cont from P3

Burnout and suicide is more common in the medical fraternity than the general public. Addressing the social determinants of health is as relevant to doctors as to their patients. The Centre for Rural and Remote Mental Health (CRRMH) has adapted the 'Act-Belong-Commit' mental health promotion campaign as one of its key initiatives. Its message is something we should all heed.

Following in the footsteps, possibly literally, of oncologist Dr Adam Boyce, surgeon Dr Sally Butchers is raising money for the Cancer Council of NSW through her participation in Stars of Lismore - Dance for Cancer (page 7). Given her enthusiasm it is unsurprising that she has raised more than her target of $20,000.

However, it can not be done alone and GPSpeak congratulates Sally and all of her team in a job well done. As Dr Binns has noted, "we all need a sense of purpose in life ... for our own health as well as for the health of others".

Artist Katka Adams overviews her exhibition, "Coming Home" -

LISMORE GALLERY
15 JUNE - 28 JULY 2019
GALLERY 5

Official opening: 6pm Fri 5 July 2019

This exhibition of drawings continues my work exploring immigration, both to Australia and to the City of Lismore, based on the traditional land of the Bundjalung people.

"Coming Home" draws on my own experience as a refugee (from Czechoslovakia) and looks at how our community has been enriched by multi-cultural settlers from around the world.

A sense of belonging is a basic human need that is hard to define or measure. While often experiencing cultural dislocation, people from diverse backgrounds have woven their lives into the fabric of Lismore, finding a new and true home.

I have become deeply interested in the journeys of so many newer residents and have spent countless hours meeting and drawing my subjects. I hope they enjoyed the experience as much as I have, and will look kindly on the results of my work.

It has been truly liberating to leave the quiet space of my studio and visit the homes of these wonderful people. What a privilege to hear their fascinating stories!

I hope my exhibition helps develops a deeper community understanding of the challenges our migrants and refugees often face as well as highlighting the valuable contributions they are making to the home we all share.

Addressing the Social Determinants of Health

by Dr Andrew Binns

In clinical practice it is very easy when looking at the causes of chronic disease to focus on risk factors and markers by performing measurements and blood tests on a patient. It is well known that abnormalities in these indices can lead to low grade chronic and systemic inflammation called meta-flammation, which in turn leads to chronic disease.

In this process it is easy to blame the patient for 'letting themselves go' with unhealthy lifestyles such as poor nutritional choices, inactivity, smoking and alcohol dependence etc. However behind these lifestyle behaviors there are more subtle causes of chronic disease that should not be ignored. These are often referred to as the social determinants of health.

Of particular concern are current environmental issues which may involve physical, political and socioeconomic factors. These often explain unhealthy individual choices people make. People who feel left out in our society are particularly vulnerable.

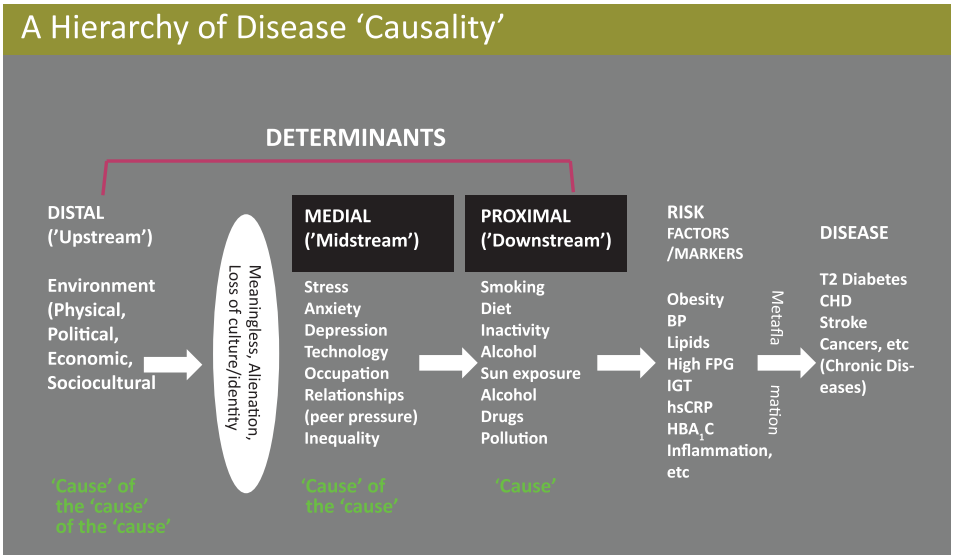
In the textbook *Lifestyle Medicine* (3rd edition) for which I am a co-author we use the acronym MAL which stands for **M**eaninglessness, **A**lienation and **L**oss of culture/identity.

Meaninglessness

Meaninglessness is a concept pioneered by Victor Frankl in his 1959 seminal book Man's Search for Meaning. He had endured years in a WW2 German concentration camp and found that survival of fellow Jewish prisoners was related to the extent that individuals had meaning and purpose in life.

This could be, but not necessarily, associated with spiritual or religious beliefs. It could also spring from attachments to family, culture, occupation, interests etc. In Frankl's case his survival depended on the meaning he attained through developing a psychotherapeutic theory around the significance of this concept called logotherapy (from the Greek logos or meaning).

There is now a growing body of literature to support the concept of deriving meaning in life being associated with better physical health, reduced risk of suicide, stroke, myocardial infarction and psychological wellbeing when faced with chronic pain. Lack of meaning can be associated with behavioral factors such as smoking, stress, inactivity, poor nutrition, etc.



People who find new meaning in life through a cause, education, job, volunteering, joining a group such as a choir can improve health and emotional wellbeing.

Alienation

Alienation can result from past trauma which can be inter-generational as often seen in Indigenous communities. Factors such as genocide, stolen land, assimilation, racism, discrimination, denial of Aboriginal history and culture, stolen generations and deaths in custody can play a part.

The resulting shame and chronic stress can lead to social isolation, rejection by family, friends, peers or society. Communication by social media leading to rejection from a group can be cruel as some young people experience. This is a worsening problem particularly for school children.

With increasing inequality seen in today's world more people are feeling left out and this can play out with political voting patterns. Those who have feelings of despair and hopelessness often have little control over their lives which in turn can have health implications.

Loneliness is becoming more common as there are more people living alone in many age groups.

Major trauma such as after an **adverse childhood experience** (ACE) is also well researched resulting in health implications in later life as previously described in **GPSpeak (Nov 2014)**.

Loss of culture and identity

Loss of culture and/or identity can arise from dispossession, displacement, conflict, climatic events and natural disasters. In Australia the health gap between our Aboriginal and non-indigenous population is well known as it is within other First Nation's people around the world. As we take in more refugees we need to provide the health support services that take into account their loss of culture and adjustment to life in our country.

It is so easy to forget the sequelae of a natural disaster such as fire, flood, drought or war after the event, but the suffering goes on and rebuilding lives can be a struggle with mental and physical health implications. Post traumatic stress disorder seems to be increasing and is a huge burden on the health system. Suicide rates are increasing particularly in marginalised communities.

The clinician's role

It is tempting as a GP to focus on risk factors rather than the predisposing causes of unhealthy lifestyle choices. It is hard in a 15 minute consultation to address the psychosocial factors in one's life when there are obvious physical health issues of the day to deal with.

However, maybe we should try harder with ideas that may lead to the need for ongoing follow up consultations or referral to other health professionals. Poor compliance with our best of intentioned advice could be addressed from the MAL perspective.

cont on P7

An often forgotten aspect of insurance

When most people think about financial planning they tend to focus on the wealth creation side of things, but often forget about the wealth protection. Building a financial plan without adequate insurance is like building a house on flimsy foundations.

Comprehensive insurance cover can be a significant expense; however these costs can be made more affordable by taking advantage of the tax deductions that apply to specific types of insurance, and to some methods of implementing insurance.

Income protection

Due to the high frequency of claims, premiums for income protection insurance can be quite high. However, they are tax-deductible, so the cost is discounted at the same rate as the policy holder's marginal tax rate. For example, someone on a marginal tax rate of 39% (including 2% Medicare levy), paying a premium of $1,000 would have an out of pocket cost of just $610, after the tax deduction is claimed. It needs to be remembered, however, that any benefits paid under an income protection policy are treated as assessable income, and therefore subject to tax.

Life insurance

While the premiums for life insurance are not normally tax-deductible to individuals, there is a simple way to gain a tax benefit. Superannuation funds can claim a tax deduction for the life insurance premiums they pay. So by taking out life insurance via a superannuation fund, a similar result can be gained as if the premium was deductible to the person taking the insurance. Using superannuation to provide life insurance has another potential benefit. As premiums are paid by the fund, it reduces the pressure on household cash flow. This may reduce the ultimate superannuation payout, but if the savings made outside of super are used wisely, the overall financial position should be improved.

The proceeds of life insurance are generally not taxable. However, a death benefit paid from a super fund to a non-dependant may be subject to some tax.

Total and permanent disability insurance (TPD)

TPD insurance is usually attached to life insurance. From a tax perspective it's treated in a similar way, so implementing it via superannuation is usually the most tax-effective way to do it. However, TPD policies held in super must have a stricter definition of what constitutes 'total and permanent disability' than similar policies held outside of super.

Trauma insurance

Trauma insurance pays a lump sum if the policy holder suffers a defined medical condition or injury. It cannot be implemented through superannuation. Premiums are not tax-deductible, but benefit payments are not subject to tax.

As with investing, the main focus on insurance shouldn't just be on saving tax. It is a protection tool. Always talk to a qualified adviser to ensure you get the appropriate level of cover, and the most tax effective way to implement it.

Please contact TNR if you have any queries from the above information or if you have other queries regarding your financial affairs.

My Dancing with the Stars experience

by Dr Sally Butchers

Having family, friends and patients going through their cancer journeys I am very happy to support the wonderful work of the Cancer Council, which raises money to help patients in many different ways and to help fund research with the aim of a cancer free future.

Less spontaneous, for a surgeon who hasn't danced properly for 30 years, was accepting an invitation for this year's Dance for Cancer in Lismore. The decision was both exciting and scary, but I soon found myself in the hands of amazing teachers - thank you to Martin and Heather Elphinstone. They have taken me from being a dance leader, the largest in my long-ago ballet class, to being a follower - no easy task. They have also taken me into the amazing world of Cuban dancing, such an elegant style and so much fun to do.

My husband Dave and fantastic friend Anne have been so supportive through this journey. From a Hool-a-hoop class to a High Tea, a Wine drive and a Bunnings' cake stall to a French movie night - we have had lots of fun raising money. We still have a Karaoke night and a Cuban night left to go. Also we have two raffles running and an on-line art auction. Local doctors including Dr Stephen Moore who has donated original works and Dr Andrew Binns who has donated some original Bundjalung art works.

Dr Sally Butchers with dance teachers, Martin and Heather Elphinstone

The Community has been amazing with its generosity in donating goods, vouchers, and money. It has been overwhelming. Special thanks go to North Coast Surgical Suites and Lismore Base Hospital Medical Staff Council for their very generous support.

For raffle tickets please email on **Sallybutchers.danceforcancer@gmail.com**

For the Art auction please go to **https://www.32auctions.com/sbdanceforcancer**

Addressing the Social Determinants of Health

cont from P5

Here are some ideas:

Focusing on a patient's interests, skills or passions in life can be useful. This often opens the way to refocus. It could be taking up art, sport, gardening, joining a community group or taking up a new hobby that can change lifestyle behavior.

Don't be afraid to ask "if anything bad may have happened to you – perhaps in your childhood". Whilst we don't need to know the detail, to acknowledge that we know, believe and understand the implications of those past distressing event can have therapeutic benefit. This is before we give any advice or refer for further support.

Loneliness leads to an unhealthy negative state of mind that can be addressed so long as it comes from one's intrinsic motivation.

Having a surgery environment that is warm and friendly to marginalised communities is helpful for gaining rapport. A good example is the use of art on the walls. For instance Aboriginal people feel more comfortable attending a practice that has art exhibited from their own community.

When it comes to healing, connection to one's culture fulfills an important role and this can be achieved through art in all its forms. Also sport can play a significant role both physically, socially and culturally.

One of the founders of the NSW Rugby League Knockout Carnival, Bob Morgan a Gamilaroi man described it this way. "The Knockout was never simply about football, it was about family, it was about community, it was getting people to come together and enjoy and celebrate things rather than win the competition football". This is a significant and popular annual cultural event since 1971.

In more recent times Aboriginal people have developed other culturally appropriate health programs that are growing in numbers attending each year. One example is the **NSW Knockout Health Challenge**.

Within a clinical practice shared medical appointments is another way of using group therapy to address the social determinants of health. (**See GPSpeak Summer 2014**)

It is important to realise how addressing only poor nutrition, physical inactivity, smoking and alcohol abuse is just the tip of the iceberg in understanding the deeper causes of chronic disease. To bring about lifestyle and health improvements, social determinants and the more distal causes of unhealthy lifestyle habits need to be addressed.

NORDOCS 2019 - a matter of communications

by Robin Osborne

The topics were as diverse as could be imagined, ranging from life as a JMO on the Northern Rivers to medical cannabis and a surgical aid program in Timor Leste (East Timor) involving doctors from Australia, Cuba and China.

Dr Zhi Kiat Sia talking on Life as a JMO in the Northern Rivers

The second annual NORDOCS gathering received sponsorship from the Northern NSW Local Health District and the North Coast Primary Health Network, with the Lismore venue being provided by the University Centre for Rural Health. It was held under the barrier-less **"unconference" format**.

The 30 attendees also heard about the history of the local medical fraternity from 1866, the challenges of rural surgical training, managing obstructive sleep apnoea, the prospects (and challenges) of greater longevity, lifestyle medicine and modern stroke management.

Despite this diversity, a common theme through many of the presentations was one that all too often features in studies involving both clinicians and patients: the need to achieve better communications on many levels.

While the issue was touched on by various speakers throughout the day-long event, and was a focus of several presentations, it was not until the final session, a panel discussion on the whys and wherefores of hospital discharge summaries (less than rigorous, most agreed) and clinical handovers, that the subject was broached overtly.

"We've got to get better at communicating," said Dr Edward Wims, Clinical Director, Mental Health for the Northern NSW Local Health District. "In a system with no fat, we need to put our heads together."

So began a lengthy discussion about poor communication between hospitals/community health and GPs, and about the urgent need for a policy, or a "line document" as one participant put it, that ensures GPs are reliably informed about when and why their patients are admitted to hospital, subsequent diagnoses and medications prescribed (and/or "purposely ceased", as one participant added), referrals and suggested post-discharge support.

It was agreed that this task should not be assigned to junior hospital doctors, nor should they be blamed for occasions when the system as it now stands does not work. A past calamitous pile-up of thousands of unread discharge documents was mentioned, the blame being unfairly attributed to junior doctors who had no control over a black-hole in the IT system.

The current situation in NSW was said by Dr Wims to be inadequate because of a budget restriction on accessing the Cerner system, and is inferior to the model in Queensland, which has better (and more costly) Cerner access. In America "documenters" are employed to compile succinct discharge summaries that are then signed off by registrars.

The issue of communications raised its head from the very start, being flagged in the title of the keynote address by Newcastle-based medical oncologist Dr Nick Zdenkowski, "Shared Decision Making", or SDM. A one-time trainee at Lismore Base Hospital he spoke of the extensive research he had done for a 2018 doctoral thesis around the dialogues between clinicians and patients with a cancer diagnosis, particularly breast, his clinical specialty.

The communications challenge, to summarise simplistically, is to what extent doctors or patients should direct the discussions, and the future treatment options and lifestyle modifications that might best take place.

Dr Zdenkowski said the "pendulum of decisional control" had swung from the "medical paternalism of old" through to an "over burdening of patients", giving them a degree of control that implied they have a complete understanding of the medical issues involved in a complex field such as cancer care.

That said, the swings have been marked and encouraging. Before the year 2000, 50 per cent of all patients preferred SDM, and 27 per cent delegated the decision to their doctors; after 2000, 71 per cent favoured SDM, and only 16 per cent felt the doctor should have the sole say. In cancer patients, the view was even stronger , with 85 per cent preferring SDM , although with chronic health conditions it was lower, only 59 per cent of patients preferring a close involvement with their care planning.

"Offering some control can help maintain patients' sense of agency," Dr Zdenkowski said, adding that the benefits of SDM have been found to include improved disease-related and quality of life outcomes, with the conversations between doctors and patients needing only slight differences in consultation times, around 2.6 minutes extra on average, according to research.

Dr Andrew Binns speaking about the social determinants of health.

The benefits of improved communications between doctor and patient also surfaced in Dr Andrew Binns' discussion of the social determinants of health, almost as an afterthought, but a valuable one.

"Most people have something in their lives that they have a passion for," said the local GP well known for his passion for the arts, especially the works of the Bundjalung community.

Recounting how he strives to connect with all patients, especially Aboriginal people, through finding a subject of interest, he added, "We need to try to find that connection, it may be art, or sport... as we know, footy is big in this area... now, admittedly that's hard in a 15-minute consultation, and there may be a need to build up confidence, to encourage follow-up appointments... but it can be most worthwhile."

He also addressed the topic of the inter-generational trauma experienced by many, perhaps all, Aboriginal patients who are impacted by the racism experienced by their families, including policies such as the 'stolen generation' history. This can have serious repercussions for their mental and physical health.

Touching on the Logotherapy concept developed by neurologist and psychiatrist Viktor Frankl, wherein the primary motivational force of an individual is to find a meaning in life, Dr Binns said that when appropriate he will inquire about a patient's familial and cultural background. Again, this communications bond may take some time to develop, but the benefits can be great.

The subject was reinforced by Dr Marion Tait from Bulgarr Ngaru Medical Aboriginal Corporation in Casino who presented on "Closing the Gap in Medical Communication", supported by staff members Karen Day and Cheree Freeburn, who had collaborated to make a learning video for clinicians featuring a less-than-ideal consultation between an Aboriginal patient and a doctor.

A video and still images also featured in the presentation "Graphic Medicine and Patient Voices" by the North Coast Primary Health Network's Sharyn White, again aimed at helping clinicians understand patients' perspectives on their care delivery, this time with some superb animation and scripts based on actual patient feedback. This project is pitched perfectly for the modern communications era, and Sharyn's work, backed by the PHN, is to be highly complimented.

Perhaps the ultimate communications challenge was highlighted in the talk by surgeon Trafford Fehlberg, a recent arrival in the Northern Rivers, who documented his assignment on a Royal Australasian College of Surgeons overseas program, supported by the Australian Government, in Timor Leste (East Timor).

With both a clinical and educational brief – helping to train in-country medical staff – the team he helped run treated a range of common, if advanced conditions, and performed routine surgical procedures, as well as trauma surgery resulting from circumstances such as road accidents and, much to the amazement of the audience, wounds from barbed arrows fired in pay-back disputes.

The Australians, Dr Fehlberg said, worked in tandem with surgical "brigades" from Spanish-speaking Cuba, whose major export is medical support for friendly nations, and China. In many cases, nationals from all three countries, as well as clinicians and trainees from Timor, who spoke Portuguese and local languages, would be involved.

"Were there communications problems?" an audience member asked Dr Fehlberg at the end of his fascinating talk.

"There were certainly many languages spoken," he replied with a laugh, "but it all worked surprisingly well."

As this innovative "unconference" heard, the same cannot always be said for communications between first-world hospitals and primary care providers within the radius of a few kilometres, and it is patients who are likely to be paying the price.

Panel Discussion - "Discharge Summary or Same Day Handover?"
From left - Drs Katherine Willis-Sullivan, Tony Lembke, Sabine Ringowski and Kat McLean.

Plenary speaker Dr Nick Zdenkowski with Drs Lynne Davies and Joe Gormaly

DrTrafford Fehlberg on Global Surgery and Timor Leste

Dr Marion Tait, Karen Day and Cheree Freeburn

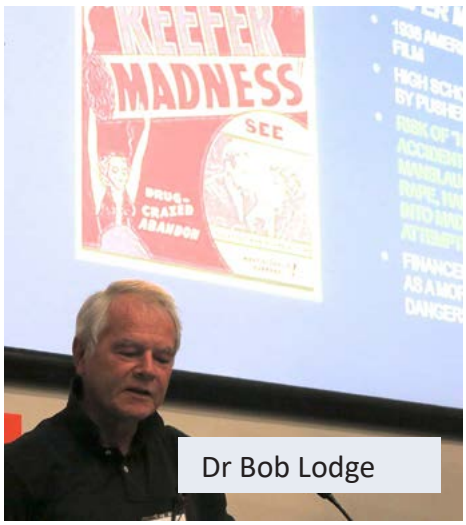
NORDOCS 2019 Gallery


Drs Bill Nardi and Richard Lucas


Dr Gratian Punch


Dr Jowita Kowslowska

Dr Neil Thompson



Dr Bob Lodge


Dr Joe Duncan


Sharyn White

Dr Marion Tait


Dr Sally Butchers

I believe ...

by Dr David Guest

I believe - That the Lord God created the universe

I believe - That he sent his only son to die for my sins

And I believe - That ancient Jews built boats and sailed to America

I am a Mormon! And a Mormon just believes

I Believe, **from The Book of Mormon, by Trey Parker, Matt Stone and Robert Lopez**

The Book of Mormon, the No. 1 hit musical in **Australia**, follows the journey of two devout young men as they set off on their mandatory two years of missionary work far from their home in Salt Lake City, Utah where the church is headquartered..

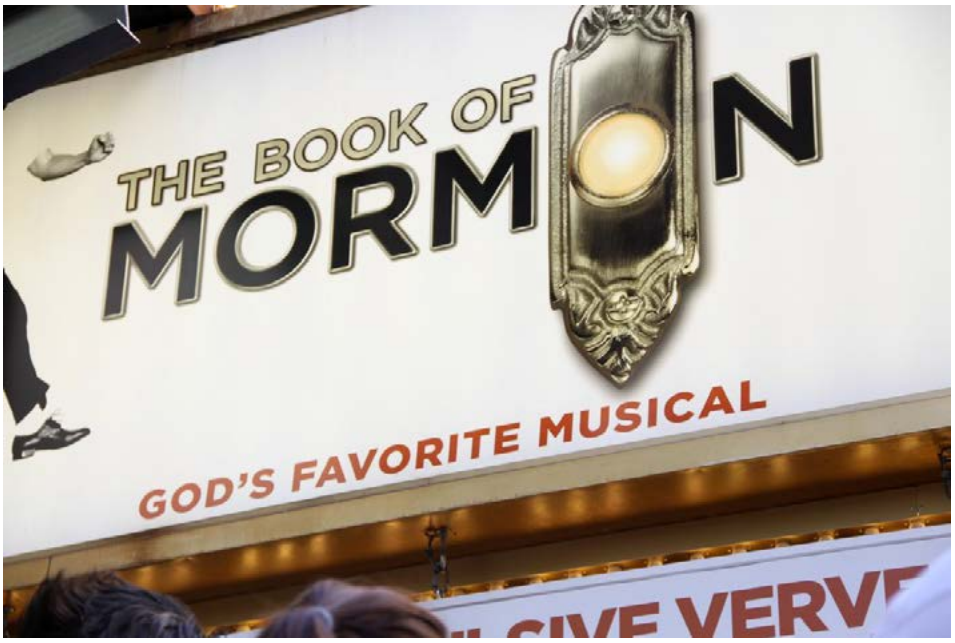
The Book of Mormon is the work of South Park creators, Matt Stone and Trey Parker, which as be expected given this pedigree is irreverent, scatalogical and confronting. In short, not the normal fare of religion, making its success with mainstream audiences seem highly improbable, even though its central theme touches a cord for the religious and irreligious alike.

As **is familiar to most Australian households** a fresh cohort of young Mormon men set off on a two-year journey to various parts of the world, some of them remote. Identified by their white shirts and black ties these Elders, as they are called, travel in pairs seeking to convert others to the Gospel, as their faith demands of them.

The musical's opening scene is set in Salt Lake City where a new group of Elders is getting ready for their mission to wherever that may be. Elder Price is handsome, overconfident and overbearing. Both self assured and self absorbed, he dreams of continuing his missionary work in Orlando, Florida, the home of Disney World where make-believe is an industry... so the task should not be too daunting. Alas for him, he is to be sent to "darkest Africa", Uganda.

Price is dismayed. Moreover, he is to be joined by Elder Cunningham who is slovenly, mendacious, lazy and generally untrustworthy. As they embark on their mission Elder Price sings of their mission to convert their assigned town to the true faith (**You and Me, But Mostly Me**).

Uganda is no Orlando. The villagers face famine and poverty, and AIDS is widespread. The town is ruled by a local despot. Violence is common and life is hard and often unpredictably short. The Mormon strike rate is low - previous missionaries have failed to convert any of the locals.



The Book of Mormon – photo Andre-Pierre du Plessis – CC by 2.0

Despite his confidence in his missionary abilities, Price also fails. His arrogance turns the villagers against him and he becomes despondent. So it falls to Cunningham to continue their missionary work.

Although clearly unqualified Cunningham makes up for his rudimentary understanding of the three testaments (the Old, the New and the Mormon) by supplementing them with his extensive knowledge of another trilogy, Star Wars, Lord of the Rings and Star Trek. His enthusiasm and the colourful world he creates for his flock is a far better one than they currently inhabit. The villagers convert, including the local strongman, and are baptised into the new faith.

As part of the celebrations the villagers re-enact the story of Joseph Smith (as told by Elder Cunningham). Price is aghast at this new interpretation of the Gospel but comes to realise that it is the believing not the truth of the story that matters. This revelation revitalises him and the missionaries stay on to continue to help the village.

While religious views are on the wane in Australia they are growing worldwide. At the last census 52% of Australians identified as belonging to one of the Christian denominations, 8% to non-Christian religions, while 30% had no religion.

Worldwide the four largest religions - Christianity, Islam, Hinduism and Buddhism - account for 75% of the world's population. Only 16% of the population do not subscribe to religious views. The remaining 10% practice one of the other 4,000 religions in the world today.

Dozens of **new religions** start each year. They often form around a charismatic leader but may splinter or disappear when the founder dies. In an attempt to prevent this some religions demand that their practitioners proselytize their faith. This can be in their daily working lives, in traditional or social media, and for some the expectation is to work as missionaries in distant places.

The tenets of these **new religious movements** vary widely. Some may take traditional teachings and expand upon them. Other religions develop completely new texts as the basis for their beliefs.

Changes in sexual practices are adopted by some religions. Celibacy or polygamy have been features of many different religions over the centuries, although the latter is now outlawed in nearly all countries. Same sex relations and marriages are also taboo in many religions.

The rise of these new religions has been seen as threatening to both established religions and non-believers alike. As a result

cont on P12

I believe ...

cont from P11

a number of anti-cult movements have arisen since the the end of WW2. However, the principle of opposing new religions goes back through the millennia and has led to dozens of wars and the loss of millions of lives. The battle for Christian hearts and minds in the Reformation and Counter Reformation attests to this.

Modern Christian anti-cult movements mostly target religions that deviate from the view that the Bible is the sole basis for the faith. As such the Mormons, Jehovah's Witnesses, Christian Scientists and the Unification Church are the most scrutinised of the larger, new religions.

The term cult has developed pejorative connotations in recent times. The lyrics of I Believe quoted above make three unverifiable statements. To most Australians exposed to religion in their childhood the first two sound unexceptional but the third is new and jarring.

All religions are new at some point in time. Reflecting on this some sociologists have said that a cult is simply a religion that has not been around for long enough (viz. cult + time = religion).

Noted writer, actor and wit Stephen Fry has been described as the ultimate Renaissance man. As a scholar and a skeptic he takes an analytical mind to the problems he sees in the world. He, however, recognises the beauty and solace that religion can bring to an individual's life. In **conversation** with another noted atheist Richard Dawkins, Fry describes how he once considered becoming a high Anglican priest. He loved the cathedral, the pomp and the ceremony. However, as he discussed with his bishop, he had a problem with the God thing. The Bishop sent him away but said he could come back once God had spoken to him. Fry is still waiting to hear.

People of all walks of life hold religious view. Medical practitioners are no exception. However, as medical practitioners, trained in the scientific tradition we attempt to base our practices on verifiable facts. Doctors will defend the statistically significant, reproducible results of a double blind, placebo controlled trial with vigour. Science is our other religion.

General practitioners have a long term relationship with their patients. They are said to be experts in the patient rather than her diseases. Where science cannot cure the patient and death is imminent alternative approaches will be tried by some patients. Religion helps many cope and deathbed conversion has a long history.

As medical practitioners we must apply our medical science to the care of the patient but also acknowledge that where this fails patients will find comfort in non-scientific approaches. Accepting this is in the patient's best interest, I believe.

Homeless services are a "field of dreams"

by Robin Osborne

They call it the "field of dreams" scenario – build it and they will come, and they have been doing just that in Tweed Heads and Coffs Harbour where the St Vincent de Paul Society, a.k.a. Vinnies, has developed weekday drop-in centres offering a range of services to people who are homeless or at risk of becoming so.

In the border location, where it is the only such centre in a highly populated area, Fred's Place – named after the Society's founder, Frederic Ozanam – is now seeing more than one hundred people a day through its doors. While registration is requested, anonymity is respected and no IDs are checked, hence a number of visitors from "Mars'" and clients claiming to be "Superman" and "Mickey Mouse". Mental health issues are relatively common amongst the homeless population.

Although personal information is not sought, many people wish to share their experiences, thoughts and problems, often having no real confidants. Staff, volunteers and university students doing practicum placements are always ready to lend an ear.

On the physical level, Fred's Place offers bathroom and laundry facilities, breakfasts and snacks, medical care (from the Kennedy Drive Medical Centre) and help with accessing government agencies using in-centre IT.

Down in Coffs Harbour a more recently opened service, Pete's Place – named after a local who unexpectedly left a bequest for "a good purpose" – the build-it scenario is seeing fifty-plus people a day coming in to use services that help them maintain personal dignity and boost their wellbeing.

Some have been sleeping rough in improvised outdoor dwellings, a situation known as primary homelessness, others have been living in their cars, couch surfing in already crowded households, or staying in low-cost caravan parks, motels and boarding houses **https://www.homelessnessaustralia.org.au/about/what-homelessness**

Pete's Place was developed with the additional help of a major infrastructure grant from Council and significant input from local Rotary and Vinnies itself, with the funds coming from regional op shop proceeds. These Vinnies' services receive no government support, with the Tweed centre running an annual community sleepout to help keep the doors open.

The facade of Harmony House, Vinnies drop-in centre for homeless people in Ballina, which is now being rebuilt.

A third such facility is now under way in Ballina, a town that, to the surprise of many, has the greatest level of homelessness in the Northern Rivers. Statistics from 2016 Census data and on-ground social service workers indicate that the greater Ballina area currently has at least 150 people who are homeless or at-risk of homelessness, with some local analysts suggesting the true number may be considerably higher.

Ready for the Fred's Place Tweed Heads community sleepout on Thursday 29 August are (l-r) Jessica Peebles, Alysia Hopkins (Fred's Place coordinator), Megan Claeys (standing), Paula Vermunt and David Holmes.

Here, Vinnies has taken a long-term lease on a building known as Harmony House in Moon Street owned by the Catholic Parish, and is refurbishing it into a three-bedroom accommodation facility for single males transitioning back into broader society. The rear of the large corner block is being transformed into a "field of dreams" drop-in centre along the lines of Fred's and Pete's Places.

The self-contained space will host a weekday service where homeless people can hear some kind words, have a much needed breakfast and snacks, wash themselves, get their laundry done, attend scheduled healthcare appointments and be referred to specialist services (including legal, financial and governmental) by qualified staff.

It will be cost-free for users and include a suitably landscaped backyard with adequate space for outdoor contemplation and appropriate social interaction between clients.

At present, Ballina has several free food services but nowhere for homeless people to get personal services or have an in-house snack without the fear of physical harassment, or at best, being stigmatised. Rostered medical care will be made available in one of the meeting rooms in the purpose built centre, scheduled to open in early 2020.

There has been strong support for the project, with Ballina Shire Council and Rous Water assisting with fee relief, Ballina State MP Tamara Smith offering help, service clubs showing keen interest, and the Ballina Shire Advocate and community radio Paradise FM ready to put their media weight behind the concept.

Keenly aware of the town's homeless challenge, the station manager of Paradise FM, Jenny Ellenbroek, quipped, "I don't even want my dog to sleep outside," adding, "How tragic that a well-off society can't adequately care for homeless people, particularly at this time of year as the cold weather moves in."

For information about supporting the Harmony House drop-in service please contact the writer (who is Vinnies communications manager) on 0409 984 488.

The writer's voice

***Janis Balodis** is an accomplished director and playwright. His works have been enjoyed and praised by the people of the Northern Rivers area for many years. Janis was born in Australia to Latvian parents who migrated to Northern Queensland after WW2. He attended Townsville Teachers' College where he majored in drama and then worked as a teacher before establishing his career for the stage. His career began in Brisbane but continued in London as director and tutor at E15 Acting School. Upon his return to Australia, his career in theatre included being Associate Director of the Melbourne Theatre Company and Dramaturg-in-Residence and Artistic Associate at Queensland Theatre Company. Other accomplishments include writing for both television and radio. His Latvian heritage has been a major influence in his works which frequently reflect the difficulties facing migration to a new country.* [Photo courtesy of NORPA]

by Janis Balodis

The writer's tool is language. We are all born into language, but what if the one we are born into is not the one we end up speaking? What are the forces in our lives that determine our use of language, that prompt or stifle our need to speak? And how does the writer find his or her authentic voice?

When I left England in 1979 to return to Australia, the staff of the drama school I taught at gave me an ironic gift, "*How to be an Alien*" by Georges Mikes. It's a humorous manual for foreigners on how to fit in to English society. The gift was doubly ironic, not only was I now leaving, but on my arrival in England I had the not uncommon experience for the children of immigrants. I had made the startling discovery that I was very, very Australian. It was as if something in my spirit had awoken after lying dormant for twenty-six years.

I talked Australian and felt Australian, and I was constantly being told that I had a European sensibility. Was that due to some Latvian influence nurtured in North Queensland? If I felt so Australian and was at times heartsick for Australia, did it mean I wasn't as Latvian as I had previously maintained? To confuse matters further, when I returned to Australia I suffered profound culture shock. The place was very familiar yet I felt like an alien here. In England I had discovered that I wasn't really Latvian, now I wasn't really Australian either. It is this sense of dislocation that informs all of my plays. At times I think I have taken the best from both worlds, with a foot in either camp. In darker times I think I have fallen between stools. The truth, as always, is in between.

I grew up in a small sugar town of about 1500 people, a third of whom were foreigners. There were only about twenty or so Latvians, three families and about eight or nine hard drinking bachelors. My mother contracted tuberculosis and had to spend nine months in hospital in Townsville, five hours away by train. As my brothers and my sister ranged from one to six years in age we were also sent to Townsville to a Queensland State Government Children's Home. Dad came down to visit us once or twice a month when shift-work and train schedules allowed. We saw our mother once in that time when she called down to us from a third floor hospital window.

Dickens had been dead almost one hundred years but he would have been familiar with the running of the State Children's Homes in the 1950s. Most of the children were wards of the State, delinquents on their way to reform school or recently released, runaways from foster homes, and a few of the stolen generation. There were only a few like us whose parents were actually paying for care. The older ones taught us the unspoken rules and protected us at school where we were often bullied. We were discouraged from speaking Latvian. English was not only the language of fitting in; it was the language of survival.

By the time we returned home none of us spoke Latvian very often. Why speak Latvian in an uncertain world where family and home can be taken away so easily, where Latvian is not only a disadvantage but can be forbidden? Our parents and their friends continued to speak to us in Latvian while we were growing up and we mostly answered in English. We did not think ourselves as Australians, but aliens who had learned to fit in.

Sixty years ago when I was a child I gave up speaking Latvian. What little Latvian I can speak is the "bread-and-butter" language of an infant. I have visited Latvia four times but have never made the effort to learn. I speak even less since my parents died.

With regards the tools of my craft, the language I use is English. It is the language I could not afford to lose. Even when writing about Latvians, it was how they spoke English that captivated me, perhaps because it is at that level that I enter the Latvian language, as a foreigner, and can share in their experience. As for my authentic voice, I'm still calling from some undefined territory in between worlds, neither here nor there, not Latvian, not Australian, and unmistakably both.

We all call Lismore home

by Robin Osborne

I been to cities that never close down

From New York to Rio and Old London Town

But no matter how far or how wide I roam

I still call... Lismore... home

(With apologies to Peter Allen)

It is widely believed, to quote a government report on culturally and linguistically diverse communities, CALD in the jargon, that Australia is "a successful and vibrant multicultural nation, with nearly half its population either born overseas or having at least one parent born overseas".

According to the 2011 Census, some 3.6% of residents in the Northern NSW Local Health District (Tweed Heads to the Clarence Valley) spoke a language other than English at home. Although the overseas-born population of Lismore is topped by those of UK heritage (1224 people), almost every conceivable group is represented here, from the "common" Irish and Scottish to the Philippines (160), PNG (49), Kenya (33), Sudan (24), Democratic Republic of Congo (18), and trailing the field, Uruguay (10, although less than this were excluded).

There is no doubt that Lismore, the major city in the Northern Rivers, is regarded as a migration success story, with a significant number of new settlers coming from countries they fled as refugees. Community and organisational support has been strong and vital. Yet for many, Lismore was not their first port of call, as **artist Katka Adams** discovered when she began immersing herself in the local migrant community to develop a project she would eventually title "**Coming Home**". The show runs at **Lismore Regional Gallery from 15 June-28 July 2019**.

GP Speak is grateful to Katka and her sitters for allowing us to reproduce some of the images in this issue of our magazine.

While her subjects, hailing from places as far-flung as Sierra Leone, Ecuador, the Netherlands, India and the USA (a five-year-old meditating), have diverse back-stories they share a common bond: all of them feel more welcome in Lismore, more "at home", than in any other part of Australia they have lived. Hence the title of Katka's exhibition.

"They told me they are much more at ease here than in other places, especially other country areas," Katka said over a coffee in The Quad precinct, adjacent to Lismore Regional Gallery, a space that has done so much to revive the heart of the flood damaged city.

Katka Adams - artist

"A sense of belonging is a basic human need which is hard to define or measure. Despite experiencing cultural dislocation, many people from diverse backgrounds have woven their lives into the fabric of Lismore, finding new homes.

"I hope this exhibition not only develops a deeper understanding of the challenges migrants and refugees face, but also the valuable contribution they bring to our vibrant community and the home we share."

Not only has Katka drawn, beautifully, these new Lismore residents but she has included a portrait of another migrant who has come to call Lismore home – herself. The self-portrait shows her with granddaughter Olive who holds a golden chain – hence the title of the work – that had belonged to Katka's grandmother.

Growing up in an unhappy family (abusive father who was loathed by her grandparents) Katka and her mother left the Czech capital of Prague in 1968 in the aftermath of the Soviet invasion of a proud country yearning for democracy.

Just seven when they arrived in Australia, she lived in migrant camps and went through a series of schools in their efforts to escape a step-father as bad as her natural one. Despite her mother's suffering mental health issues she attained the HSC at Sydney Girls High, doing 3-unit art, in 1980, marrying Russell Adams (nowadays a long-serving physician at Lismore Base Hospital's emergency department) shortly afterwards.

Katka went on to study at the Sydney College of the Arts, majoring in painting. Their first child, Millie, was born at the end of her final year, and at the age of six weeks accompanied her parents on their move to Lismore in 1985.

Despite the qualification, Katka decided to undertake a TAFE course in art, feeling that, "I needed skills-based instruction rather than the more conceptual art education delivered in Sydney". Clearly it has paid off, as her latest exhibition again shows.

Golden Chain - pastel on paper

This year's hanging follows her 2018 artistic exploration of her own migration experience and was sparked by a realisation that she is deeply interested in the journeys of others. Each picture in the show is accompanied by a description of the subject/s, adding a layer of meaning to the works beyond the visual.

In total, "Coming Home" is a testament to the subjects, to the artist and to Lismore, which can be proud of rolling out the welcome mat to people from all over the world, most of whom, it seems safe to say, would never have heard of our city before they came here.

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How much does it cost?

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Further information

For information regarding this program, including start dates and how to register, please contact Currumbin Clinic Day Programs on 07 5525 9682.

Meet Dr Brook Burchgart

BMBS (Flinders University, Masters of Psychiatry (NSW Institute of Psychiatry), FRANZCP, Cert Addiction Psychiatry, Bachelor of Occupational Therapy (UQ)

Dr Brook Burchgart is an Addiction and General Adult Psychiatrist in full-time private practice.

Dr Burchgart initially graduated as an occupational therapist through the University of Queensland in 2000.

She specialised in mental health rehabilitation within forensic mental health and early intervention psychosis services in both Brisbane and London until 2007.

In 2011, Dr Burchgart graduated from medicine with distinction from Flinders University and was awarded the WACrammond Prize in Psychiatry. She trained in a number of Sydney metropolitan hospitals including Liverpool, St Vincent's and Prince of Wales Hospitals.

In 2017 she relocated to the Gold Coast and has since worked at Gold Coast University Health Service District specialising in addiction, chronic pain and dual diagnosis services. She is a registered OTP prescriber in NSW and Queensland.

Dr Burchgart is actively involved in research in the areas of addiction psychiatry and has presented on topics relating to opioid prescribing in patients with comorbid physical and psychiatric conditions.

She is a Faculty Member for the Queensland Chapter of Addiction Psychiatrists.

To arrange an appointment or referral, please phone Dr Burchgart's Currumbin Clinic consulting suite on 07 5586 4950 or fax 07 5525 9686.

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The Robinson Review

by David Guest

"Half the money I spend on advertising is wasted; the trouble is I don't know which half". This aphorism is attributed to the founder of the first major American department store, John Wanamaker. It might be argued that the same can be said of medical care.

The Medical Benefits Review Taskforce (the Robinson Review) is drawing to a close. Set up in 2015 by then Health Minister, Sussan Ley, at the suggestion of the Dean of The University of Sydney Medical School, Professor Bruce Robinson, the review has aimed to modernise and rationalise the 5,700 odd items on the Australian Medical Benefits Scheme (MBS).

Many of the item numbers had not been reviewed in over 30 years, were outdated or redundant, or just sufficiently vague as to being open to "innovative" interpretation.

Taking longer to complete than expected, the Review established 70 Clinical Committees to look at various aspects of the MBS. The Committees comprised clinicians with domain expertise as well as representatives from medical practitioners in associated disciplines, general practitioners and consumers. The aim of having a more broad membership on the Committees was to avoid potential claims that the Committees might just feather their own nests.

Most of the Committees have completed their work. Their recommendations have been made available to the public for comment and also have been sent to the various specialty Colleges for feedback. The last step in the process will be for the Taskforce to review the Committee reports and associated feedback before sending their own final report to the Minister. Not unexpectedly, some in the profession are not happy with various recommendations.

Last month, in his most candid speech to date on the Review, Professor Robinson noted the wide variation in some procedures in different parts of the country. The variations were so large that they could not be explained by patient demographics or service accessibility. Professor Robinson went so far as to state that 90 to 95 per cent of practitioners followed usual practice, implying that 5 to 10 per cent pushed the limits of acceptability.

The Review has been criticised for its recommendations not being evidence based. However, it commissioned some evidence based reviews and the Clinical Committees were charged with looking at the available scientific literature in their specialty areas.

Nevertheless it was acknowledged that in many areas there is no evidence base, a point that neurosurgeon Brian Owler also made when he was the AMA president in 2015:

"I don't need an evidence-based review to say that I should remove the tumour from a child that presents through the emergency department because I know they're going to end up dead within the week if I don't do it"

The Taskforce has deliberately not undertaken a repeat of the failed MBS Relative Value Study that ran from 1994 to 2001 but was never implemented. However, it looked broadly at the income generated from claiming MBS items. Professor Robinson's estimate is that such claiming roughly equates to an hourly rate of $250 to $500 although there are some clear cut outliers on both sides of this band.

Reflecting this approach the Specialist's Clinical Committee has proposed several changes for physician reimbursement, including a "move away from initial and subsequent consultations, differential rebates for specialists and consultant physicians and additional payments for complex planning, to a time-based structure similar to that applied in general practice".

The Committee has also recommended a progressive reduction in the telehealth component of consultation item numbers to zero. It recommends the savings achieved be reinvested in promoting the health and economic benefits of telehealth for specific patients to the medical and general community through education programs run by Primary Health Networks and others.

To improve communication between practitioners Case Conferencing is to be specifically supported by Discharge Planning and Community Case conferences. They also recommend a new Treatment Planning Case conference that may allow patients to make a more informed decision about their future treatment options.

The Committee envisions discussion of evidence based clinical practice guidelines, transparency regarding costs of specialists' services and documentation of discussion of the patient options in the proposed treatments.

Finally they recommend uploading of these Case Conference documents to the My Health Record. They propose underwriting the cost of doing this by giving incentive payments to physicians for uploading a minimum number of documents. This would be analogous to the current scheme available to general practitioners for Shared Health Summary uploads.

The changes may significantly alter clinical practice for some specialists while having little impact on others. Unsurprisingly, those below the band $250 to $500 band are seeing value in the review, while those above see the government seizing on the high value items to cut them by more than 50 per cent.

The Australian Society of Anaesthetists has called for Professor Robinson's resignation, portraying his speech as "betraying an unprofessional approach that seems to underlie aspects of the rushed review and should lead to his removal."

For general practitioners the thrust of the review is to incorporate aspects of the Medical Home model of care into the MBS. Chronic disease patients and the elderly could register with their preferred "Medical Home" general practice and receive streamlined and ongoing managed care and timely medication reviews, and get easier access to allied health services.

Longer consults would be encouraged by creating a Level E, 60-minute consultation and making Level B consults at least six minutes. There would be a higher rebate for home visits for those patients on a care plan.

In an earlier forum in 2015 Professor Robinson had said his focus was on making the MBS more efficient and "not to save money." The government undermined this approach at that time by cutting 23 items from the MBS and axing bulk billing incentives for pathology services.

That was yet another low point in the profession's relationship with the government and given its experience of government actions over the decades doctors are justly sceptical that the MBS review would not be used to further cut medical incomes. It seems likely that Professor Robinson's review may yet join those of Professors Jackson and Horvath as simply a tool for furthering the government's political agenda.

A specialist in the glass being half-full

by Robin Osborne

Not to be confused with 'oncology', although the similarity would make an ideal game show question, Oenology is the science and study of wine making, *oinos* being the Ancient Greek for wine.

While obviously linked with viticulture, the term for vine-growing and grape-harvesting, oenology is the end stage of the process (apart from the drinking) and along with a good nose and palate the mastering of it requires tertiary study.

Although Joseph Michael ("Joe") Duncan says he only "stumbled into wine making" he did complete a BSc (Wine Science) at Charles Sturt University, reflecting during our interview that because he was no good at art, "wine making became my version of painting... there are so many things you can change."

Yet the biggest change for Joe has been in his career path, but more of that in a moment as we follow the Sydney high school graduate to Mittagong in NSW where, in 1999, he planted 25,000 vines, a mix of Pinot Noir, Riesling, Sauvignon Blanc, Pinot Gris and Merlot, on land owned by the Marist Brothers.

Trainee Oenologue Joe Duncan with a barrel of Riesling during the 2002 harvest at Hugel et Fils cellars in Riquewhir, Alsace, France.

Before they matured to harvest he went to France to top up his skills at ground zero, working in the cellars of Hugel et Fils in Riquewhir, Alsace and the picturesque Domaine Laroche **https://www.larochewines.com/en** where he held the colourful title of "Assistant Oenologue".

Later stints with the noted Evans & Tate vignerons in WA and a Berrima vineyard further boosted his knowledge at a time when Australians were increasingly catching the wine bug.

But there was a downside to the occupation many would think ideal, and it began with the simple, although surprising, realisation that, "Vineyards are not very social places."

Perhaps those who make the stuff don't dare over-imbibe in their products.

Seeking a more gregarious profession he added teaching to his skills portfolio, helped by a Graduate Diploma in Education from UNE Armidale. As a teacher he would do volunteer stints in Bourke, Cambodia and the Solomon Islands. He regards community service as a high priority in his life.

While comfortable in teaching, the academic challenge of medicine and a desire to work with a broader range of people took him from the classroom and, in time, into the hospital environment.

With two degrees behind him Joe was accepted into The University of Sydney, graduating in 2011 as a Bachelor of Medicine and Bachelor of Surgery. Last year, after earlier posts as a physician trainee at Lismore Base and Gosford Hospitals, he completed advanced training in respiratory and sleep medicine through the Royal Australasian College of Physicians.

Dr Joe Duncan savouring a glass of tasty Shiraz.

His specialisation as a Consultant Respiratory and Sleep Medicine Physician now takes precedence over his ability as a wine maker (and sometime craft beer brewer), but he still savours a glass of good vino when one comes his way.

For the record, it should be noted that Joe Duncan does not recommend drinking more wine to patients experiencing sleep problems. Indeed, one must look closely at his extensive CV to spot "wine science" in the list of his qualifications, experience and awards.

Foremost amongst his career objectives Joe notes a commitment to medical education in regional Australia – "I've always wanted to work in the country" – and lectures to undergrad students doing rural placements, supervised by the University Centre for Rural Health North Coast.

Along with his wife Emily, a dietician at LBH's Integrated Cancer Care Centre, he moved to the Northern Rivers in February this year. He's looking forward to having a garden, knowing how well things grow here, but doubts that grape vines will be in the mix.

"It's so lush and everything simply powers, but the sub-tropics isn't an ideal grape climate or terroir," Joe says. "It looks like I'll be buying my wine from now on."

Time to wake up to "sleep apathy" risks

by Robin Osborne

The report of a federal parliamentary inquiry into sleep health awareness was released in April 2019.

It was drafted by eight Members of the House of Representatives Standing Committee on Health, Aged Care and Sport, following a reference from the Health Minister. Over several months it held interstate hearings, received 138 expert submissions and 30 exhibits, and considered key previous studies, including 318 NHMRC-supported research grants relating to sleep or sleep disorders from 2000-2018.

It seems fair to ask, given the exhaustive (and expensive) nature of the exercise, whether all this work tells us anything new. The temptation is to suggest not, as clinicians and the broader community seem well aware that, "Sleep is a fundamental human need and, along with nutrition and physical exercise, it is one of the three pillars of good health."

As everyone agreed, "Sleep is a crucial element in the maintenance of health and wellbeing."

However, we may not have adequately considered that one in every ten Australians is not getting enough quality sleep [7-9 hours per night for adults, more for young people] for our own good, nor how best we might remedy this situation.

"Society's apathy towards sleep has, in part, been caused by the historic failure of science to explain why we need it - sleep has remained one of the last great biological mysteries."

Professor Matthew Walker, Why We Sleep: The New Science of Sleep and Dreams (Penguin Books 2017), cited in the parliamentary report.

The Committee's response to this apparent crisis includes a key recommendation to develop a national education and awareness campaign to help address the identified barriers to improved sleep health. As they explained:

"This campaign should emphasise the important role of sleep in a healthy lifestyle as well as the health and wellbeing risks that are associated with inadequate sleep. In addition, the awareness campaign should provide people with practical advice on how they can improve their sleep health.

"Some of the great leaps in public health

have happened because of successful national campaigns — be it in fitness (for example the Life. Be In It campaign), smoking prevention or our efforts to halt the spread of HIV."

They said such a campaign should draw on the proposed educational strategy developed by the Australasian Sleep Association and the Sleep Health Foundation as part of their 2019 federal budget submission.

The parliamentary inquiry, coyly titled "Bedtime Reading", was introduced as "a report we hope will give you a good night's sleep", suggesting the contents to be so soporific that a bedside copy might solve the problems identified.

In fact, this consideration of "the prevalence, causes, and symptoms of inadequate sleep and sleep disorders, as well as the treatment and support available for sleep disorders" is never dull, and certainly timely.

Committee Chair Trent Zimmerman MP notes that getting inadequate sleep is linked to a range of serious physical and mental health conditions such as diabetes, heart disease, and dementia, and on behalf of his cross-party colleagues says the awareness campaign would highlight that regularly foregoing sleep due to the pressures of a busy lifestyle will have health consequences.

"It is estimated that 7.4 million Australians are regularly not gaining the recommended amount of sleep... In 2016-17, this cost the Australian economy $26.2 billion... If the impact of lost health and wellbeing is included the estimated cost rises to $66.3 billion"

At a time when many people work longer hours and remain wedded to electronic devices this may be easier said than done. Further, the timing of the report's release in the lead-up to a federal election may not have helped. There are no signs so far of major parties urging Australians to change their sleeping practices, and like many a worthy endeavour, the funding for the sleep project could well determine its success.

The report's 11 recommendations include:

- The Australian Government prioritising sleep health as a national priority and recognising the importance of sleep to health and wellbeing alongside fitness and nutrition
- Developing a national approach to working hours and rest breaks for shift workers
- Enabling GPs to more effectively refer patients to diagnostic sleep studies
- Urging the Australian Government, in consultation with the RACGP and other key stakeholders, to assess the current knowledge levels of GPs, nurses and psychologists in relation to sleep health, and to develop effective training mechanisms to improve the knowledge of primary healthcare practitioners in diagnosing and managing sleep health problems
- Ensuring that all Pensioner or Health Care Card holders with moderate to severe obstructive sleep apnoea, regardless of their location, can access a free trial of CPAP therapy and if successful receive free ongoing CPAP treatment; and assess the potential benefits of providing subsidised CPAP therapy across the broader community.
- A review of sleep health services funded under the MBS
- Providing practical information in relation to sleep hygiene and measures an individual can use to improve their sleep

A recommendation given close attention was the need to fund research into the effects of the use of digital devices on children's sleep health. A submission from the Australian Council on Children and the Media noted concern that the use of smartphones and tablets in the evening is negatively affecting children's sleeping patterns.

The ACCM cited a survey that found almost half of Australian children "regularly use screen-based devices at bedtime, with one in four children reporting associated sleep problems."

An icy wind blows through NSW

by Robin Osborne

Despite a passing resemblance to Kenneth Hayne AC QC, who headed the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Professor Dan Howard SC presides over a very different kind of inquiry. Known as the Special Commission of Inquiry into the Drug 'Ice', the NSW Government-convened roadshow held two days of hearings in Lismore in mid-May.

According to Professor Howard, a former president of the NSW Mental Health Review Tribunal and former acting judge of the District Court of NSW, "Lismore is one of the regional communities where the use of crystal methamphetamine is of particular concern."

While he didn't use the term "epidemic", it was certainly raised by others, including police and health care workers.

As several witnesses explained, the usage of the drug known colloquially as "ice" tends to be concentrated in the lower socio-economic sectors of the populace, with significant penetration into Aboriginal communities where it has caused a raft of health, social and law-and-order problems.

The Commission had sat previously in Sydney and after Lismore was scheduled to move on to Nowra and Dubbo, centres where local media would also report alarming statements such as, "People living in rural and remote areas are 2.5 times as likely to use methylamphetamines as those in major cities."

In fact, the evidence presented in Dubbo in early June was, if anything, even worse than would transpire here: "It took 15 people to restrain one violent man who was highly intoxicated on ice in a hospital," The Sydney Morning Herald reported.

"It looked like everyone from Dubbo was there from the police force," said senior Dubbo Base Hospital ED nurse Christopher Waters said. "It was such a racket. We called the police to ask them to come in and save the day."

Mr Waters said he had been assaulted "many times", including being king hit by patients who had taken ice or a mix of other amphetamines... 'It is an amazing drug and it brings this incredible strength, and people ended up getting hurt."

Before the Commission was launched a raft of scary reports about what is viewed as the scariest of drugs jolted the state government into action, although it was nearly three years since the federal government released **the report of the National Ice Taskforce**.

Canberra's report noted that, "Proportionally, Australia uses more methamphetamine than almost any other country, and the number of users continues to grow". However, words alone failed to end what is so often billed, as we again saw recently, as the "ice epidemic".

The challenges are easily stated – society (but who, exactly?) needs to eliminate supply and end people's desire to try and continue to take this highly addictive drug. So far, the saying and the doing are poles apart.

Into this vortex stepped the NSW Government, creating an inquiry that would look into, 1) The nature, prevalence and impacts of the drug crystal methamphetamine – a.k.a. 'ice' – and other illicit amphetamine-type stimulants (known as ATSs), 2) The adequacy of current measures to target crystal methamphetamine and other illicit ATS, and 3) Options to strengthen NSW's response, including law enforcement, education, treatment and rehabilitation responses.

This has entailed casting a wide net aimed at gathering the views of addiction experts, drug and alcohol counsellors, primary and tertiary level medical practitioners, lawyers, police and, not least, illicit drug users themselves. The lists of those who gave evidence in the Lismore hearings (and the other Commission sittings), along with complete video recordings of their testimony and other relevant material, can be viewed at **https://www.iceinquiry.nsw.gov.au//assets/scii/witness-lists/lismore/Lismore-Witness-list.pdf**

Transcripts of the two-day Lismore session run to around 400 pages, and are challenging to summarise, given the breadth of the inquiry and the complexity of the subject matter.

Those sharing their expertise on the misuse of "ice" and other ATSs included medicos Dr Rob Davies, Emergency Director, Tweed-Byron Hospital Network, Dr Edward Wims, Clinical Director, Mental Health – Richmond Clarence, Dr Bronwyn Hudson, GP and VMO, Emergency SMO, Byron Central Hospital, and Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service.

It was an impressively expert group, even before the addition of NSW Police, the Aboriginal Legal Service (ALS), MERIT, the Buttery, NSW Ambulance, FACS, ACON, and Northern NSW Local Health District/ Mental Health.

But as is often the case, there was an elephant in the room, and as so often, its name was alcohol, that legal drug frequently attached to sport sponsorship yet seldom portrayed as one of the "dirty drugs" that breaks families apart, ruins lives, and, as many of the witnesses noted, often co-exists with the use of illicit substances such as ATSs, including "ice".

Early in their evidence both Drs Davies and Hudson observed that while "ice" and other drugs are of significant concern, alcohol ranks foremost in the abuse experienced by many of their patients.

"Alcohol is the biggest drug issue of the community," the former noted, "which often seems to be missed."

- The Special Commission of Inquiry into the Drug 'Ice'

Dr Hudson stated simply: "The main substance of concern is alcohol."

As might be expected, however, "ice", ATSs and the Northern Rivers' local specialty, cannabis, were the main focus, with local police commander Supt Toby Lindsay providing information on users (tend to be from lower socio-economic groups), costs ($50 a 'point' of "ice", $400 a gram, $15-$30 for MDMA (ecstasy) pill, etc), types of usage (often beginning with cannabis, then lacing it with methamphetamine, then the pure drug).

The Supt noted that the challenge of controlling "ice" users included their extreme strength, inability to comprehend police instructions, the need to deploy more police responders and to use OC (pepper) spray and handcuffs. The likelihood of attending officers experiencing PTSD was also raised, as it had been by the police union.

However, violent events of this kind were relatively rare, he said - contrasting with the Dubbo situation where arrests for possession of amphetamines (including ice) was double the state average, and the rate of methamphetamine related hospitalisations was 40 times greater. Here, there is perhaps one violent instance every month or two, with high-visibility policing helping to disrupt supply, and the Crimestoppers/dob-in-a-dealer campaign resulting in 3,400 local information reports for manufacture, supply and use.

Edwina (Eddie) Lloyd, a solicitor with the Aboriginal Legal Service and a Lismore City Councillor, voiced concern about the penetration of "ice" into the Aboriginal community and its association with offences such as break and enter, and domestic and other violence. In the cells, clients can be "aggressive, impulsive and violent", she said.

Cr Lloyd estimated that 90 per cent of ALS clients misused substances, "often ice", adding, "Rarely do clients not using drugs commit a crime."

Urging an end to emotive terms such as "ice addict", "junkie" and so on, Cr Lloyd said people suffering "substance misuse disorder" could and should receive better detox and rehabilitative support through services already operating here. These include MERIT ("Fantastic in turning lives around"), Circle Sentencing, the Buttery and the Involuntary Drug & Alcohol Treatment Program (IDAT), under-resourced as they often are, as well as other initiatives that run successfully elsewhere, such as Koori and Drug Courts.

Her plea for the enhanced funding of such services was echoed by all Commission witnesses over the two days of hearings, with a stress on drug treatment being treated as a medical priority rather than a judicial one. As Dr David Helliwell put it, "There's more value for money from the health system than the justice system."

Cr Lloyd, chair of her Council's Social Justice and Crime Prevention Committee – "Our community's cry for help", as she put it – expressed this view in plain terms: "It's time for our politicians to put the guns down... the war on drugs is over."

It seems not all politicians come armed for combat, as was shown by Janelle Saffin, the recently elected State MP for Lismore (which takes in Tenterfield, Lismore, Kyogle, Murwillumbah and part of the Tweed Valley), who, surprisingly, was not informed that the Commission was coming to town, and upon seeking a presence was told the hearing was booked out and had no room for her.

In a tendered statement to the Commission Ms Saffin (a lawyer and long-time social activist) noted having seen "a distinct increase in the use of the drug ICE, its local manufacture, its distribution, the increasing number of charges, paralleled by its increasing usage, the mayhem it causes the addicts themselves, their families, their communities, and the impact on the health system."

Like other witnesses, she said, "Our primary societal response is to charge and sentence and not provide rehabilitation... but the fact is, we simply do not have the rehabilitation services available to respond to this. I am told that the waiting list at 'The Buttery' is some four to six months.

"The MERIT program fares no better and has a long waiting list and excludes alcohol use, the primary drug of choice that also causes mayhem... ICE may be the primary drug of choice, but is frequently accompanied by other drugs, including alcohol and a variety of destructive behaviours."

She added that a recent NSW Legislative Council inquiry had found a dearth of available services. While the NNSW LHD said the local most popular drug continues to be alcohol at 38 per cent, followed by opioids 24 per cent, cannabinoids 10 per cent, and amphetamines 15 per cent, the "resulting mayhem" from the last category was "exponentially greater".

Again, like others who appeared, Ms Saffin advocated for Drug and Koori Courts, which do not have to be 'Taj Mahals', and hoped the Commission's report, due for release in October, would recognise the use of "ice" and other drugs as a major health and social issue, and respond accordingly.

Judging from the testimony presented to Commissioner Dan Howard, she is by no means alone.

Lismore MP Janelle Saffin's inaugural speech to the NSW Parliament

Discharge summary versus clinical handover

This article first appeared in **MJA Insight+**. The authors and administrators are the **GPs Down Under Facebook group.**

In our earlier article we described the concept of "passing the baton" when talking about transfers of patient care. All patients come from their communities and to their communities they shall return. In this transition from tertiary hospital to primary care, they benefit from timely, safe, effective clinical handover as defined in the **National Safety and Quality Health Service Standards**.

In primary care, communication matters, perhaps more so than in tertiary care. Words matter. The language we use matters. It informs thought at conscious and subconscious levels and influences behaviour.

The words "discharge summary" evoke feelings of an administrative process at best, and various unsavoury processes at worst. The accidental discharge, the dishonourable discharge, and the smelly discharge all come to mind. The words "clinical handover" instantly sound more professional. They reflect the sort of interaction between clinicians of which we want to be part. Clinical handover is a term familiar to both clinicians and administrators. It is taught in medical schools around the country and practised between junior and senior doctors within our hospitals.

Transition of care is well known to be a time of maximum risk: "**Adverse events are seen to increase particularly during a transition of care, when a patient is transferred between units, physicians and teams.**"

Clinical handover is a recognised, evidence-based, structured and essential safety mechanism for minimising this risk. Remember, all patients come from their communities and to their communities they shall return. Their community doctor, their primary care physician, is their GP. Patients deserve the best clinical handover we can provide, whether transitioning into or out of our hospitals.

Junior doctors in hospitals presently perform the clear majority of clinical handovers to primary care, labelled as "discharge summaries". According to the *Discharge Summary – Literature Review*, published by Queensland Health in May 2017 (not available online):

"Junior doctors perform the clear majority of discharge summaries:

- Many interns have a flippant attitude to the completion of discharge summaries and have a low perception on the importance of a safe handover of care;
- Most medical education programs provide minimal education on the completion of discharge summaries;
- Most interns learn from each other with little input or guidance from registrars and consultants;
- Interns tend to 'lump' discharge summaries together, often completing the summaries on patients they have never met."

This frequently happens after the transition has occurred. To borrow from our legal friends, you cannot sell what you do not own. How then can you transfer the care of a patient you have never cared for?

Junior doctors report that they have limited supervision and lack templates or guides to help them produce a comprehensive and useful handover for community-based care whereas they receive a considerable amount of training for internal clinical handover.

Medical practitioners frequently use **ISBAR (introduction, situation, background, assessment, recommendation)** to guide clinical handover. A recent GPDU discussion highlighted that the Gold Coast University Hospital was moving to an ISBAR format for clinical handover to primary care. This was seen by many in GPDU to be a significant step in the right direction. ISBAR for the clinical handover to primary care aligns with hospital handovers and can only improve the transfer of care. **Brewster and Waxman** recently proposed amending ISBAR slightly to K-ISBAR by adding some kindness into the equation. Taking the opportunity to actively incorporate empathy and understanding into the primary care handover would be a great place to enhance collegiality across community and hospital teams.

When deciding who is tasked with a clinical handover within the hospital, it is unlikely that this would be handed to the most junior member of the team, and exceedingly unlikely that it would be delegated to someone who had never treated or met the patient. Within hospitals, it is expected that a clinical handover occurs at or before the time a patient's care transitions to another team or provider. Why should this be any different for the clinical handover back to the GP?

In our first InSight+ article, we used the analogy of passing the baton. But what happens when the baton is dropped?

Dr Mandie Villis **recently wrote a heartfelt plea** for hospital doctors to inform GPs when patients passed away on their watch. Discussions around primary care clinical

- more on the concept of 'passing the baton'

handover are now **occurring around the country** and pockets of significant improvement are being made. Momentum is building in regard to formally recognising and changing the language used from "discharge summary" to "clinical handover". Several hospital and health services have, or are in, the process of implementing "same day" or "24-hour" clinical handover policies, and ultimately the best practice standard will be that this clinical handover occurs at the time of transition of care.

My Health Record (MHR) has been touted as a partial solution to the problems that have traditionally plagued clinical handover. It is important, however, to remember what MHR is and what it was created for. It is a repository of information for patients – a "shoebox" of documents akin to the jumble of receipts we burden accountants with at tax time. It is not, nor was it designed to be, a communication tool for clinicians. The baton transfer cannot occur within the MHR shoebox. It was not designed to replace current clinical record systems or current communication channels between clinicians. These limitations and precautions are outlined in the **RACGP My Health Record guide for GPs**:

"My Health Record is not designed as a substitute for direct communication between healthcare providers about a patient's care, and should not be used in this manner. Healthcare providers must continue to communicate directly with other healthcare providers involved in the care of a patient through the usual channels, preferably through secure electronic communication."

The **Australian Digital Health Agency** states:

"The My Health Record system supports the collection of Discharge Summary documents. When a healthcare provider creates a Discharge Summary document, it will be sent directly to the nominated primary healthcare provider, as per current practices. A copy may also be sent to the individual's digital health record."

Mission creep of MHR is real, with multiple reports on GPDU of GPs stumbling across clinically relevant information in MHR rather than receiving a timely clinical handover. Important clinical information is "pushed" into MHR and the receiving clinician is not "pulled" to it by any sort of notification. There is no handover without closing the communication loop. Health professionals and organisations must ensure that clinical handover occurs with the intended recipient at the time of care transition. A copy uploaded to MHR for the patient to access, as an archive, may serve as a safety net if all else fails, but should not be relied on as the only source of communication.

Drs Katrina McLean, Michael Rice, Nick Tellis

Hospital systems must support and value the safety delivered by effective clinical handover to primary care. This will reduce the readmission rates to hospital care and improve the care patients receive. Patient care and practitioner wellbeing should not continue to be compromised due to the hospital culture of a discharge summary being an administrative task undertaken by the most junior team member. The challenges of high administrative burdens, inadequate staffing and unpaid overtime all need addressing. Junior doctors should not be left alone grappling with piles of outstanding discharge summaries to complete on patients they have never met.

The patient journey can be tracked, important milestones bookmarked, and plans documented as they are formed so that when it's time for a transition, the "baton" is ready. The need for handover cannot come as a surprise when the patient's trajectory was plotted from the day they were admitted. Adequate clinical staffing levels with protected time for clinicians to prepare clinical handovers should be a key performance indicator in hospital care. Proactive strategies must be put in place to identify and document who will be receiving the clinical handover. The culture that prevails within many of our hospitals needs to change.

Safety and quality bodies, such as the **Australian Commission on Safety and Quality in Health Care** through its National Safety and Quality Health Service Standards, and the **Australian Council on Healthcare Standards** through its accreditation regime, can provide effective oversight. All clinicians must lead in continuous improvement in "best practice" for quality and safety in transition of care both into and out of our hospitals.

Let us recognise and applaud our hospitals and health services leading the way in acknowledging discharge summaries as the clinical handovers that they are. May 2019 bring us all closer to high quality, timely, safe and patient-centred clinical handovers.

Dr Katrina McLean is a Gold Coast-based GP, Assistant Professor in the School of Medicine and Health Sciences at Bond University, and a GPDU administrator.

Dr Michael Rice is past president of the Rural Doctors Association of Queensland, an educator of students and registrars, a long term resident and rural GP in Beaudesert. He's a keen user of social media.

Dr Nick Tellis is passionate about great general practice. He's a proud GP, beachside Adelaide practice owner, and new father. He blogs at www.partridgegp.com when not on GPs Down Under. He can be found on Twitter @partridgegp

LISMORE THEATRE CO.

Lismore Theatre Company will present Robert Harling's award winning play Steel Magnolias. Steel Magnolias will bring audiences a production of sass, style and sisterhood from the big-haired 1980s.

The play is alternately hilarious and touching. The play chronicles the lives of six women who frequent Truvy's Beauty Spot in Chinquapin, Louisiana.

Lismore Theatre Company's production of Steel Magnolias is directed by Sylvia Clarke. Sylvia is delighted to be able to work with six talented local female actors who have blossomed into their roles.

Truvy Jones - Jacquie McCalman

Annelle Dupuy-Desoto- Elyse Knowles

Clairee Belcher - Jenny Dowell

Shelby Eatenton-Latcherie - Sinead Fell

M'Lynn Eatenton- Lisa Walmsley

Ouiser Boudreaux - Sharon Brodie

Venue: Rochdale Theatre

603 Ballina Road, Goonellabah

Performances: July 5-20

(Friday and Saturdays 7.30pm, Sundays 2pm)

Bookings **www.lismoretheatrecompany.org.au**

ACRRM Registrar home in the Clarence

by Joanne Chad - Program Coordinator

Maclean local Dr Rhiannon Faulkner has been all over NSW in the early stage of her budding medical career and is now happy to be home for her final year of training.

The 29-year-old has just commenced her ACRRM Paediatric Advanced Skills Training at Grafton Base Hospital through Australian General Practice Training (AGPT). This means Dr Faulkner can complete her postgraduate medical training just a stone's throw from her home town of Maclean.

After completing the University of Newcastle/University of New England Joint Medical Program through UNE campus, a residency in Tweed Heads and GP training in Tamworth, Dr Faulkner has returned home after 10 years.

"It's really nice to be back home where I want to work. It's helping me establish how things work in the area and get involved in the health care system, to meet people and to be a part of that network," Dr Faulkner said.

"It's nice to give back, it's really nice to come in and have people ask where I'm from and be able to say, actually, I was born at Grafton Base Hospital."

Dr Rhiannon Faulkner with Mr Craig Shields – HETI Rural and Remote Senior Program Manager

Dr Faulkner said she had dreamed of becoming a general practitioner in the Clarence Valley, and hopes that this year of training can bring her a step closer to fulfilling this dream.

"Hopefully before I finish my Paediatric training I can start meeting with some local practices to see where there may be job opportunities for me," she said.

With the support of HETI's NSW Rural Generalist Medical Training Program, Clarence Health Service and GP Synergy, UOW Clarence Valley Regional Training Hub has been able to create new ACRRM and RACGP accredited training opportunities for medical trainees. Craig Shields from HETI's NSW Rural Generalist Medical Training Program recently visited the Clarence Valley and had an opportunity to meet Dr Faulkner and the team. This enabled the Clarence Health Service to showcase the comprehensive medical, nursing and allied health education programs available in the region.

For more information about Clarence Valley medical training opportunities please contact University of Wollongong Program Coordinator Joanne Chad at **clarencevalley-rth@uow.edu.au** or phone 0438 265 938.

Communication is the key to our Health Service

Recently our Local Clarence Valley Doctors were provided with the opportunity to do just this. Over 20 of our local Doctors from Grafton and Maclean Emergency Departments, various Hospital Departments and from the local General Practices, all participated in a medical conference aimed at improving collaboration between departments and strengthening working relationships. The beautiful rainforest setting at Angourie Rainforest resort offered the ideal environment to connect, reflect and discuss important issues and cases in a non-threatening and open environment.

The medical conference included a social dinner, a keynote speaker, music, case discussions, clinical updates and an interactive simulated Emergency Scenario, in which our team of doctors and nurses worked together to manage an Emergency situation in real time with limited resources.

The key note speaker, local sailing legend, Kay Cottee, was a stand out for the group. She spoke to the team of doctors about her magnificent adventure and achieving her goal of becoming the first woman to perform a single handed circumnavigation of the world. Kay's inspirational story sparked a lively and passionate discussion amongst the medical team, and highlighted the importance of an effective team, even in what may seem to be a solo mission.


Dr James Hodges, Dr David Clough, Medical student Kieran Davis, Dr Tunga Batiya, RN Belinda Nichols, Dr Ifaan Jetha, and Dr Rhiannon Faulkner, participate in a simulated emergency scenario.

by Greta Enns – UOW Placement Facilitator

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Armidale – 3/121-123 Allingham Street
Inverell - St Elmo Medical Practice, 27 Oliver Street

FRACS Fellow of the Royal Australasian College of Surgeons

Confessions of a wound convert

by Dr Dan Oxlee

We tend to have mixed feelings towards recent converts, admiring, say, the newly reformed smoker for their hard work but being irritated by their lecturing of those recalcitrants still puffing away. Our vegan teenage niece is close to being shoved out the door but what would we do without the passion of youth? Our colleague returns from a weekend workshop and is suddenly giving us lectures on the value of manual handling and OH&S.

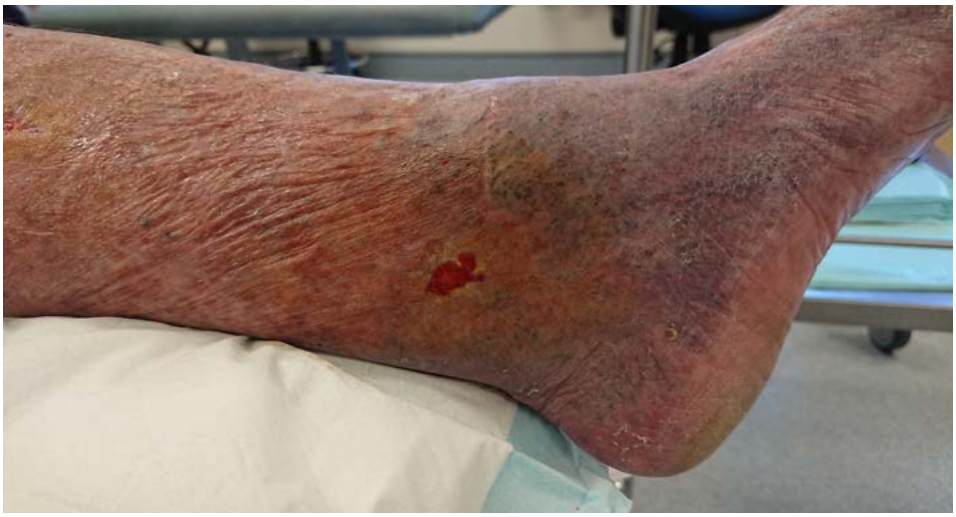
I must now confess to finding myself a convert – to the wonderful world of chronic wound care. After 23 years in the one practice in Nimbin I was somewhat adrift when I left it almost two years ago. I landed on the shores of a multi-disciplinary wound clinic in Brisbane (**Wound Innovations**) and it has become my new medical home.

I thought I had a pretty good understanding of wound care, having done a diploma in dermatology, sewn up hundreds of acute wounds, written a multitude of scripts for fluclox and cephalexin, swabbed wounds, wet wounds, I've dried wounds and covered nearly all of them with hopelessly inadequate dressings that have probably made them worse.

I've looked into the dressing cupboard of our clinic or the hospital and wondered what all these things were for. I've leapt to action with my script pad when presented with wound swab results showing a Staph or a Pseudomonas, emptied whole tubes of Solugel onto wounds because I remembered that "wounds need moisture to heal". I've found myself peering over a circumferential weeping angry wound with a nurse on the other side, both of us thinking the other was the expert and hoping they will come up with a solution.

I now realise there is much more to wound care than I thought. It's also simpler. Our clinic has lots of fancy equipment such as ultrasonic debriders and Vac dressings but we seldom resort to these. A systematic and consistent approach with dressings that anyone can apply generally works very well. I'm horrified to think that I really knew so little and there is virtually no teaching of chronic wound care in undergraduate or postgraduate education. I'd like to change that.

As GPs we are regularly at the coalface of managing difficult longstanding wounds. My wound management was a long way from optimal and I suspect that's true for many of us.



This small but painful wound has been present for two years. Wounds like this can often be healed in weeks with appropriate care.

So as a convert I would like to spread the word.

There are a few principles of chronic wound care that make a wonderful difference. At the risk of sounding like that pedantic surgeon we tried to avoid in 4th year tutorials, a thorough history and examination of the wound and the patient is vital. As most chronic wounds are on the legs, vascular assessments are imperative. It is almost impossible to heal an arterial wound unless the supply of oxygen is corrected. Looking and feeling goes a long way. A hand held doppler is also very useful, as is a good relationship with a vascular surgeon.

As for that cupboard with its confusing array of foams, pads and gauzes, good dressing choice helps us manage the wound bed, keeping the bacterial load in check and wicking away the exudate. While bacterial biofilms are a common cause of delayed healing in chronic wounds it is rare that we use antibiotics, regardless of swab results.

We do however regularly debride wounds. Chronic wounds love it. Taking a simple scalpel blade to a wound and clearing out slough, debris, hypergranulation and scale can make a big difference.

Venous ulcers need oedema and exudate control. It is as simple as that. Compression is the mainstay of treatment. 80% of venous ulcers will heal in twelve weeks if provided with best practice, yet 70% of venous wounds do not even get compression. While a script for the pharmacy can provide the patient with a good long term pair of compression stockings, Tubigrip makes a wonderful short term option while we are dealing with the wound.

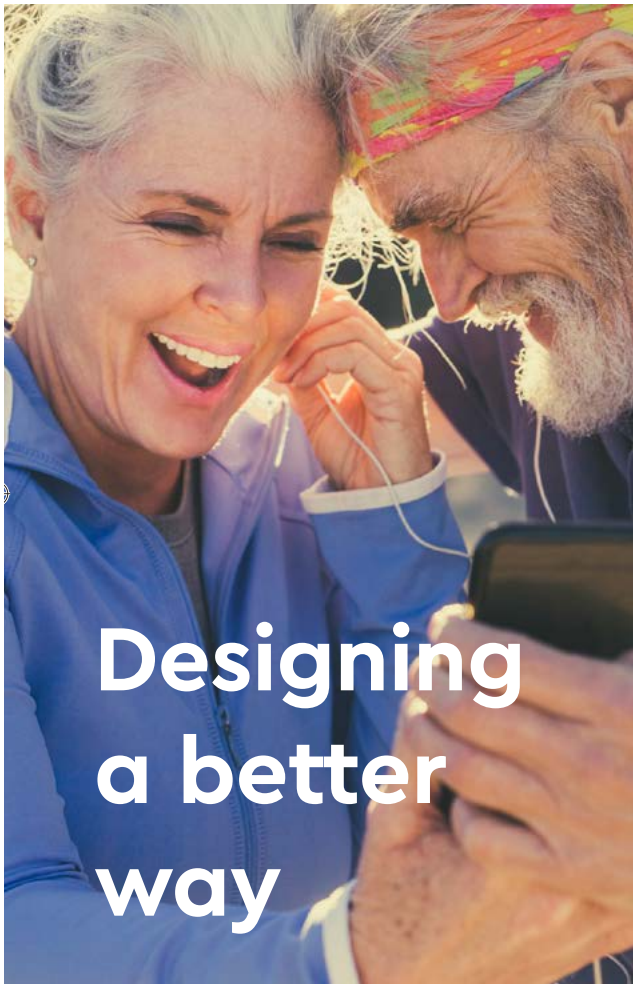
We know that pressure injuries require pressure offloading but so do diabetic foot ulcers. Here a podiatrist can be very helpful. These wounds are some of the most stubborn wounds but I have seen some fantastic results with total contact casting applied by a skilled podiatrist. The result can not only mean a healed wound but also avoiding amputation.

A small but painful chronic wound that needs regular dressings can be a nightmare for many people. Patients long for the day they can take regular walks, go swimming or just play with the grandchildren. It is very rewarding to be able to turn that around. Some wounds have been there for over twenty years and patients are often resigned to them never healing.

Always consider the possibility of malignancy in a non healing wound and biopsy if in doubt. Many malignant wounds don't look like those typical rodent ulcers we see in the text books.

I am very happy to give advice on wounds. I am available to visit GP clinics and assess and treat wounds on site. For details feel free to call me on 0427 891 410 or **doxlee@aussiebb.com.au**.

Wound Innovations provides in-clinic and telehealth services as well as wound education particularly to aged care facilities. Our number is 1300 968 637.



We believe care should be focused on the patient, the individual. That care should be available when and where the patient needs it most. And it should be designed to help give patients the best possible life outcomes.

Professor David Christie
Radiation Oncologist
Professor Christie visits Byron Bay clinic once every six weeks and has extensive experience in treating all major cancer types including prostate brachytherapy, urological cancer, lymphoma, skin cancer and benign disease.

He works closely with Dr Steven Stylian, Medical Oncologist, to ensure patients have access to a multi-disciplinary model of care.

Consulting locations:
GenesisCare
Byron Bay Specialist Centre
Suite 6 / 130 Jonson Street
Byron Bay NSW 2481

Radiation oncology treatment locations:
GenesisCare
Premion Place
39 White Street
Southport Qld 4215
Ph 07 5552 1400

GenesisCare
John Flynn Private Hospital
Inland Drive
Tugun Qld 4224
Ph 07 5507 3600

For further information about the Byron Bay clinic service please contact our Tugun centre:
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Book Reviews by Robin Osborne

Superbugs - The Race to Stop an Epidemic

Matt McCarthy

Scribe 290pp

This study of the nature, causes and possible cures of microbial infections is as complex as the human body itself but far leaner than the recent works of Siddhartha Mukherjee (The Emperor of All Maladies, and The Gene) whose jacket quote is effusive: "An amazing informative book that changes our perspective on medicine, microbes, and our future."

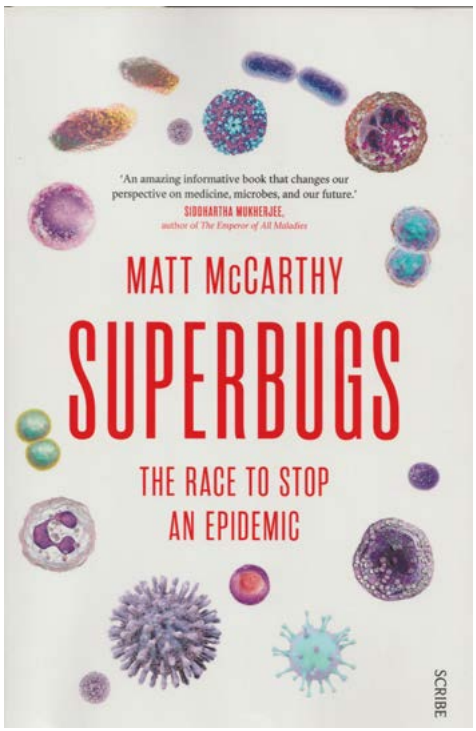
As is so often the case, the story begins at war when the now-legendary Alexander Fleming, "Little Flem" as he was known, was caring for British soldiers in France at a makeshift base that doubled as a wound-research laboratory.

"The young doctor grabbed a damp cloth from his surgical bucket and dabbed the soldier's leg, cleaning mud, blood clots, and shreds of uniform from the gaping exit wound. He picked up a scalpel and carefully excised a small swatch of fabric from the man's muddy pant leg.

"This piece of clothing, Fleming hoped, would solve one of the most puzzling questions of World War 1: Why were so many soldiers dying of tetanus?"

After the conflict, during which more than 17 million military personnel died, many of them from tetanus, Fleming returned to his lab bench in London, spending the next decade "trying to devise ways to destroy harmful bacteria and improve the treatment of infections".

In 1928, a chance observation led Fleming to discover that a fungus called Penicillium rubrum could kill Staphyloccus bacterium, "one of the pesky organisms that was so prevalent in battlefield wounds", as the author puts it. This accidental finding in a discarded petri dish led to the discovery of what Fleming called a slow-acting antiseptic... "He dubbed it penicillin".



So the tale progresses, both forwards and, as it happens, backwards, with research showing that significant levels of tetracycline, "a broad-spectrum antibiotic still used today", was found in the skeletal remains of Sudanese mummies dating back as far as 350 AD. Chinese medicine used an array of them, while bacteria from the red soils of Jordan are still used to treat infections.

"The 1950s would come to be known as the golden era in antibiotic development, a time when advances in molecular biology led to all sorts of new medications that markedly increased life expectancy. In fact half of the drugs in use today were discovered during that decade."

So far we are only 20 pages into this intriguing book (and I have bypassed a number of characters and events), and nowhere near Dr McCarthy's work with drug resistant infections in US hospital patients, his inspiring relationship with mentor Dr Tom Walsh and their clinical trial with what turned out to be a super-bug-busting drug known as dalba(vancin), one dose of which was found to be highly effective against a range of intractable infections. This journey through the shoals and rapids of MRSA, VRE, VRSA, sulphanilamide, daptomycin, nystatin and the rest is truly fascinating, both for the clinical and lay reader, and provides great hope for victory in the battle against the skin infections that affect twenty million people worldwide each year.

Sometimes, however, we are brought down to earth with a thud. When the author's father-in-law is battered by a multiplicity of ailments, he finds that no drugs would help, and the only response was surgery.

"I felt the supreme limitations of antibiotics... what Bill needed was for someone to go in and just cut out the damned infection. The advances made by Fleming... and all the others were worthless... when he needed a cure, it was a team of surgeons with knives who saved him."

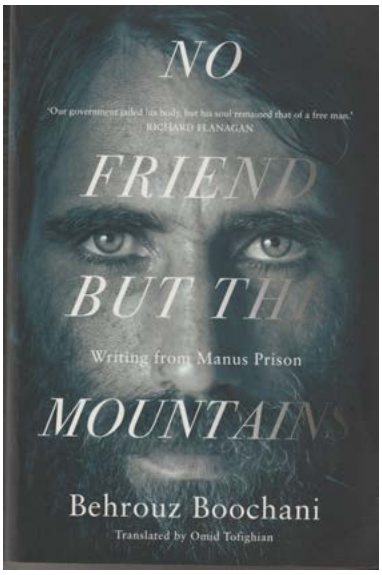
So the search goes on, whatever the frustrations.

"Despite nearly a century of experience with antibiotic discovery, we still don't really know where to look or how best to isolate the molecules beneath our feet. Is Borneo [in 1952 a missionary dispatched a muddy soil sample to a friend at distant Eli Lilly - eventually it was developed as vancomycin, from "vanquish", which could kill penicillin-resistant bacteria] better than Bora Bora?

"What about the desert? Or the ocean? We hunt for antibiotics in sewage and polluted lakes and the intestines of insects, but the results have been inconsistent. There's a lot of dirt to sift through. We need a better way, or at least a more focused process, to identify the next big thing."

This book discusses many big things, along with microscopic ones, and the two combine to provide a valuable insight to a challenge facing us all, whether doctor or patient.

Book Review



No Friend but the Mountains

Behrouz Boochani

Picador 374pp

Of the hundreds – or is it thousands? – of asylum seekers who have been detained in the "holding centres" of Christmas Island, Port Hedland, Nauru, Manus and Port Moresby none is likely to be as recognisable as the Kurdish-Iranian Behrouz Boochani whose book, dictated to an interpreter via WhatsApp on his cell phone, has taken the Australian literary world by storm.

The Victoria Prize for Literature, valued at $100,000, was followed by a special award at the NSW Premier's Literary Award ($10,000), neither of which he was allowed to collect in person. Further absurdity came with his appearance as a "virtual" guest at the recent Sydney Writers' Festival, this time dialling in, at least legally, from the capital of neighbouring PNG, which supposedly has sole say over local immigration matters.

Subtitled Writings from Manus Prison, where he spent six years in detention, this deeply moving and highly intellectual memoir (he holds a Masters degree in political science) is a detailed account of refugee passage from Indonesia by leaky, over-crowded boat to Australia, and then transfers through our detention gulag. In his company were Burmese Rohingya, Afghans, Iranians, Iraqis... older, younger, sick, confused, traumatised.

"The Manusian official reads out a script about Manus and life on the island. He finishes by saying we have to respect the laws of the land. He threatens that if we don't we will be taken to court and imprisoned. An unambiguous threat, right there under a tent as hot as hell...

"Can it be that I sought asylum in Australia only to be exiled to a place I know nothing about? And are they forcing me to live here without any other options?

"Clearly, they are taking us hostage. We are hostages – we are being made examples to strike fear into others, to scare people so they won't come to Australia."

Interspersed with the author's poetry and his deep political analysis of what he calls the prison's "Kyriarchal/colonial" system of control, the book is a damning insight into why Australia's management of asylum seekers, the majority of them genuine refugees, has done so much to sully our human rights reputation.

If anything positive might emerge from this sorry decade-long episode it is that Boochani's insider view of "off-shore processing" will never date and his words, superbly translated by Omid Tofighian, whose positions include an appointment at The University of Sydney, will haunt many Australian politicians for years to come.

Dungarimba Wandarahn

Goori Country

The Quad was recently (23 – 26 May 2019) the site for an animated art screening by artist and creative director, Craig Walsh. The Quad precinct sits protected by the Lismore Regional Gallery, Lismore City Library and the Northern Rivers Conservatorium and has become an area for many creative activities. Dungarimba Wandarahn (Lismore place of learning) was a multisensory installation telling the story of Bundjalung elder, Aunty Irene Harrington, as remembered and told by herself. As an Aboriginal girl, Aunty Irene learnt the traditional Widjabul language at home but, when she attended Lismore High School, her language and culture were 'swept under the carpet'. The experience of watching her story teaches us about her personal journey in growing up which is reflective of the local Aboriginal population in the days of assimilation.

The Quad ia a community space in the Lismore CBD which is used for many events such as this one.

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