

# GPSpeak

Autumn 2020



| GPs tread the boards

| New Grafton jail opens soon

| GP guide to dementia

Quarterly magazine of the Northern Rivers Doctors Network



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### ON THE COVER:

Alstonville GP Luke Hogan, pictured on our cover, was one of three doctors who performed in Ballina Players’ excellent production of *Wicked, The Untold Stories of the Witches of Oz*, in late 2019. The highly regarded amateur company is preparing to blow audiences away with more blockbuster shows this year, including *Priscilla; Queen Of The Desert* and *Mamma Mia*. The Northern Rivers abounds with quality theatre, as outlined on page 23 of this issue of GPSpeak.

Cover photo: Jens Krause, member of Ballina Photography Club

### EDITORIAL TEAM

**Dr David Guest** Clinical Editor  
[info@nrgpn.org.au](mailto:info@nrgpn.org.au)

**Dr Andrew Binns** GP Contributor  
[info@nrgpn.org.au](mailto:info@nrgpn.org.au)

**Robin Osborne** Editor  
[editor@nrgpn.org.au](mailto:editor@nrgpn.org.au)

**Angela Bettess** Design  
[angela@whiteduckdesign.com.au](mailto:angela@whiteduckdesign.com.au)

### GPSPEAK ON THE WEB:

[www.gpspeak.org.au](http://www.gpspeak.org.au)

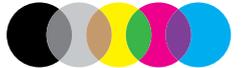
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## Editorial - 20/20 vision

*I want it all, I want it all, I want it all, and I want it now*  
- Queen, 1989

Civilisation has come a long way in 5,000 years. The English philosopher Thomas Hobbes described the natural state of man as “solitary, poor, nasty, brutish and short”. He argued that this could be addressed by ceding one’s liberty to the Crown in exchange for an enjoyment of the benefits that society brings. An individual’s **basic needs** for food, shelter and clothing would thus be met.

Times have changed. More recently economists have argued that sanitation, education, healthcare and the internet be added to the list. That’s progress, but on the North Coast many of us will have patients living below the new poverty line.

With an expanded list of **wants** and **needs** the government is faced with the dilemma of finding the **ways and means** to fulfill them. Since wants are endless this is an impossible task.

The best the government can do is prioritise the needs and find the most efficient way to deliver the services. In totalitarian states the party determines the activities, in democracies every few years the electorate can choose from two or more alternative paths.

While many regard this as an improvement it does not address the problem of the **tyranny of the majority**. In pluralistic societies like America and Australia the majority of the electorate will vote, perhaps manipulated by media old and new, in their own self interest. While this is rational for the individual it raises problems such as degradation of the environment for future generations and tax laws that see the transfer of wealth from the young to the old.

So how best can the government address the wants and needs of the Australian public?

The last 30 years has seen a progressive withdrawal of the government providing services directly to the public. Many previously public services at both the State and Federal level are now “contracted out” to private companies.

Contracting for human services can be

a difficult task and one that has exercised the minds of bureaucrats since the early 80s. Professor Gary Sturgess has examined the issue from both sides of the negotiating table. On page 19 we review his paper, Just Another Paperclip, on the history of contracting; its failures and successes.

On page 21, Beyond Paper Clips, we look into some of the recent government reports on commissioning in aged care and mental health. **Neglect, the interim report on the Royal Commission into Aged Care Quality and Safety**, was not complimentary about the current system. The final report is out later this year and will have specific recommendations about ways to improve the system.

**Serco**, the large multinational services company, has contracts with a number of governments around the world for human services. The controversial company Serco has had a presence **in Australia** for 30 years. On page 6 former HealthSpeak editor, Janet Grist, writes about the new Clarence Correctional Centre due to open near Grafton within the next four months. What might this entail for the local area? A recent forum in Grafton raised concerns about the 400 Aboriginal men and women to be incarcerated there and what this will mean for their families. Panelist, Professor Judy Atkinson, has looked into prisoner care elsewhere in Australia and has some suggestions for the Grafton Community.

On page 9 Dr Andrew Binns addresses the issue of the medical care of prisoners. Not surprisingly prisoners in NSW have high levels of chronic infectious disease and mental health problems. Dr Binns works at the Balund-a correctional rehabilitation service for Aboriginal patients south of Tabulam. Medical care in the new Grafton jail is part of the contract with Serco and will be provided by their doctors and nurses. Dr Binns is particularly concerned about the transfer of medical care of Aboriginal patients on leaving jail. The current system from NSW Justice is abysmal and it is unclear whether it will improve under Serco.

**Australia’s incarceration rate** has risen 50 percent in the last 20 years. Rather



David Guest  
Clinical Editor

than building more prisons there have been calls for smarter strategies. North Coast local, Fiona Allison, is Chair of the Justice Reinvestment Network that argues some of the current funding be reassigned to communities with high rates of imprisonment and incarceration. Part of the JR approach is to collect data from the community and government to examine how effective the current programs are.

As the **American juror Louis Brandies** noted over a hundred years ago, “Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.” Fiona Allison is also keen to work with the Grafton community on JR initiatives.

The quality of government contracts comes under considerable strain in times of government austerity. The cheapest tender beats the best value bid. Services are restricted and cut back.

North Coast general practitioners will be aware of the frustrations and delays patients have in accessing local public hospital surgical services. Lists are restricted and the delays can have adverse consequences for patients. GPs’ inboxes fill up with notifications of pending operations and procedures rather than definitive reports with recommendations for future management. Requests for Admission are rejected by the hospital in the hope of keeping their statistics on target. It’s a whole new take on **buffing the chart**.

On page 29 we report on Dr Howard Hope’s attempt to solve some of these problems. Possible solutions are in the offing but it is a work in progress.

## Editorial - 20/20 vision

continued from P3

When there are problems in government programs the response is often to hold a Royal Commission that can make recommendations for possible solutions. Sometimes the recommendations are too costly or unacceptable for political reasons. The recently released partial government response to the Special Commission of Inquiry into the Drug 'Ice' is no exception to the latter, as GPSpeak editor Robin Osborne reports on page 25.

Another alternative for the government in dealing with expensive outcomes is to introduce new regulations. Several years ago the Department of Health disallowed the co-claiming of mental health items with standard consultations and only permitted variation in exceptional circumstances. In January this year the Department sent letters to GPs who deviated statistically from the norm with high rates of co-claiming.

The letter suggests that the affected GPs

may wish to review their claims and pay back any erroneously claimed monies. For those GPs where this would be difficult the letter suggests a formal Department audit of their claiming could be helpful.

The Department, through the Prime Minister's **Behavioural Economics and Research Team** (BERT), is helping GPs achieve compliance with these new Medicare regulations. Assisting deviants become compliant is only one of the facilities BERT offers. GPSpeak will address "nudge health economics" in a future issue.

On a brighter note on page 10 Rachel Guest speaks with Clinton Schultz, a Gamilaroi man and the force behind **Sobah**, the most boutique of boutique zero-alcohol beers. Australian alcohol consumption has decreased by one percent per year over the last 10 years and this trend is higher in young adults.

Hipster beer has been part of this trend

but Clinton is on the cutting edge by combining native Australian bush flavours in a zero-alcohol beer. Young men and women are becoming more concerned about their health and are choosing to reduce their alcohol consumption. As **Scott Galloway**, raconteur and Professor of Marketing at New York University, has noted when plugging advertisers in his biweekly podcast, **Pivot**, "Nothing makes you look sexier to the other party goes at the end of the night than **ATHLETIC BREWING**." (America's leading no-alcohol beer).

Mankind has made huge progress in the last 5,000 years. We have never lived longer, been healthier or wealthier. We hope to continue this trend into the next generation. There are challenges but working on smart solutions is the best option and something to which we can all contribute.

- David Guest

## Nordocs is now launched

At the AGM of the Northern Rivers General Practice Network on 19 December 2019 it was resolved to widen the membership of the organisation to include all doctors from Tweed Heads to Grafton. The meeting also resolved to change its formal name to the Northern Rivers Medical Network (NSW) Limited and to trade under the name "Nordocs".

The Board members of the organisation are Nathan Kesteven, David Guest, Bronwyn Hudson, Louise Imlay-Gillespie, Joe Gormally and Trafford Fehlberg. While the Board is composed of three GPs and three specialists it is planned to widen its membership to include representation by doctors in training and other practitioners from outside the Richmond Valley.

The new direction for the organisation was outlined by Chairman, Dr Nathan Kesteven, in his **Annual Report for 2019** with the focus in the coming year being on communication and education of medical practitioners on the North Coast.

As a result the organisation is reviewing

its administrative structure with the intention of holding two face-to-face meetings this year. It will work closely with its partners the North Coast Primary Health Network, Northern NSW Local Health District, North Coast GP Training, the Gold Coast Medical Association and General Practice Gold Coast.

GPSpeak will continue in its current format for the rest of 2020. The Editorial Board, which is unchanged, comprises editor Robin Osborne, medical editor David Guest, contributing editor Andrew Binns and graphic and web designer Angela Bettess. Importantly for our "bottom line" the committee remains keen to work with our valued sponsors and advertisers in keeping members abreast of the important medical issues for our area.

GPSpeak will continue to be published quarterly and the **organisation's newsletter** and **articles** are posted throughout the year.

Our chief communications channel is the **Nordocs Facebook group**, which is

# NORDOCS



Northern Rivers Doctors Network

open to all medical practitioners living or working in the Network's footprint. Correspondence should still be sent to the old addresses of Nordocs Board <[nrgpn-board@lists.nrgpn.org.au](mailto:nrgpn-board@lists.nrgpn.org.au)>, Nordocs Info <[info@nrgpn.org.au](mailto:info@nrgpn.org.au)>, GPSpeak Advertising <[ads@nrgpn.org.au](mailto:ads@nrgpn.org.au)> and GP Speak Editor <[gpspeak-editorial@nrgpn.org.au](mailto:gpspeak-editorial@nrgpn.org.au)>, pending upgrades to the websites.

The GPSpeak Editorial Committee and the Nordocs Board welcome feedback from all members of both the medical and general community on how we can better serve and inform the people of our fabulous region.

David Guest

Nordocs, Secretary 2020

## “Good, fast, cheap. Pick any two.”

by David Guest

“Good, fast, cheap. Pick any two.”

This business aphorism reflecting the economics of scarcity is relevant to most aspects of human behaviour. If something is good, demand rises quickly and suppliers are then faced with three choices; increase the price, delay the delivery time for the goods or services, or reduce quality.

One can escape from these economic constraints only through developing new techniques or innovations that allow for faster, better or cheaper delivery without compromising any of the other parameters, at least to any great extent.

Doctors have a fair idea of what constitutes good medical practice. GPs have encapsulated these principles in the basic tenets of the “Medical Home”. In Australia the [Medical Home](#) is a person-centred offering, comprehensive, continuous and coordinated care that is readily accessible and of high standard.

For patients the question is much more difficult. They have no domain specific knowledge of their problem. They, largely, cannot tell good quality from bad, at least initially. However, they readily understand time and money and may base their decisions on those parameters.

As can also be the case with lawyers and accountants, helping a customer get through a major life event or crisis will cement most professional relationships. The professional is in there for the long haul and looks after the patient’s/client’s interests. Their value comes to the fore on those occasions when the stakes are high.

Medicine differs from most other disciplines in that the government is a third party to the transaction. Like patients themselves the government cannot readily assess the quality of the care provided. However, unlike patients, that does not change much over time. The focus for the government thus becomes buying the greatest number of services at the cheapest price.

As the sole insurer of medical services at the primary care and specialist level the government has extensive monopsony power over the medical profession. It uses

this to counter the extensive power the profession has in determining its own prices.

Medicare rebates have never kept pace with inflation and have been frozen for seven of the last eight years. The fixed price has resulted in more frequent but shorter consultations over time. It is argued by most medical practitioners - and patients would hardly disagree - that shorter consultations are of lesser value.

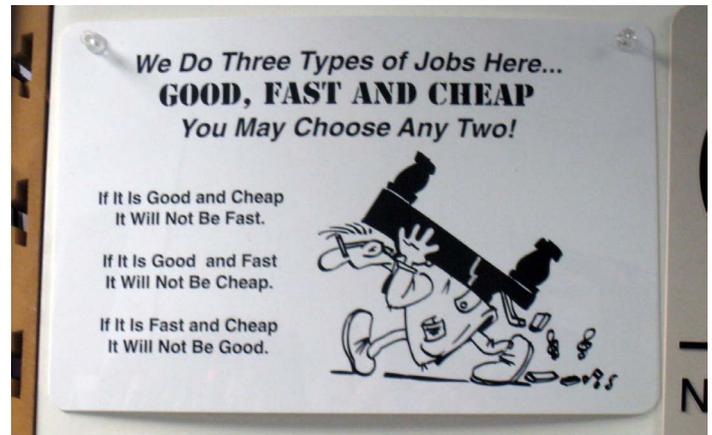
In Australia co-payments are permissible. Patients can make an out of pocket payment for a medical service from a particular practitioner for what they deem to be a “better product”.

Providing a “better product” is also good for the provider. Practitioners derive more satisfaction from their work when they can afford to provide a higher quality of care and are incentivised to explore ways of doing things better.

The relationship between control over your environment and happiness was established many years ago. In the eighties Australian trained epidemiologist Michael Marmot examined the relationship between increased work stress and poorer health, and [control over the work environment](#) in the British civil service; the higher up in the pecking order and the more control you have over your workflow, the better your health and well being.

In other countries co-payments are not permitted. Doctors in these systems have less control over their working arrangements and are frequently demoralised by the system. Primary care practitioners in those countries are far less happy with their lot than [Australian GPs](#).

Each year the Australian Productivity Commission reports on the health system. The [2019 report](#) was released in late January 2020 and found that Australian general practice was largely fulfilling the criteria of the “medical home” with more



Good fast cheap Katy Warner Flickr crop CC BY-SA 2.0

than 90% of patients agreeing that the GP listened closely, showed respect and spent enough time with them. Over 95% could afford the GP visit and medications and 80% got an appointment within an acceptable time frame.

The Commission’s report largely confines itself to data and statistics, preferring inferences to be drawn by others. It did note, perhaps wryly, that dentists outperformed GPs on all criteria except... timeliness and affordability!

The continuing squeeze on GPs’ incomes has made general practice a less attractive specialty. The failure of the GP training program to fill its [quota last year](#), combined with the high percentage of GPs approaching retirement age, suggests a skill and workforce shortage is likely in the coming years. Given the trends for an ageing population and high burden of chronic disease such a development could be catastrophic.

The AMA and RACGP have long argued for increased remuneration for general practice and the point is once again made in the [AMA’s submission for the 2020-2021 budget](#). With their past record of success - i.e. the lack thereof - in influencing government financial decisions GPs should not be too hopeful of meaningful increases in the near future.

With the mounting pressures on the entire health system it remains to be seen if the current trends towards using [behavioural economics](#) and specialty services will successfully replace general practice for an ageing population.

# Clarence community raises concerns about local mega jail

by Janet Grist

With a construction cost of \$798 million – around four times that of the Christmas Island detention centre, whose architecture it resembles closely - the Clarence Correctional Centre (CCC) will hold the record of being Australia's biggest and most expensive jail. It may also become the nation's most unpopular, based on reactions from local community members in recent months, as the construction phase comes to an end.

The centre, close to completion at Lavidia, is located on rolling rural land some 27 kms from Grafton, the 'capital city' of the Clarence Valley. Cattle graze, the paddocks have greened up after recent rain, and heavy equipment works seven days a week, not only on the CCC project but on the Woolgoolga-Ballina highway construction. A sceptic might suggest that this other work, massive in scale, has helped the CCC work to hide in plain sight.

Despite claims of its economic benefits to a struggling area, and an improved way of managing sentenced inmates, many locals are increasingly worried about the impact it will have on their region.

The CCC is designed to house 1700 inmates on a footprint of more than 90,000 square metres. This cohort will include around 300 Aboriginal men and 100 Aboriginal women.

It is the largest prison contract ever awarded in Australia, the winner being a consortium called Northern Pathways, which includes Macquarie Bank, the NSW Government and the publicly listed British company Serco whose track record – in the UK, Australia, NZ and elsewhere – has been, to put it politely, chequered.

Serco, which will operate the jail when it opens this July, has said the operational contract is worth \$2.6bn over 20 years. It is recruiting 600 workers for the facility.

The first forum to discuss the effects of the CCC on the community was held in November 2019 in Grafton. Its main focus was the impact of the new jail on women, and Indigenous women in particular. Around 40 people attended from across the community, along with an expert panel comprising Bundjalung woman Emeritus Professor (SCU) Judy Atkinson, an expert in intergenerational trauma and healing;



From left: A/Prof Pauline Clague, Emeritus Professor Judy Atkinson, Ms Debbie Kilroy and Dr Andrew Binns at the community forum.

Debbie Kilroy OAM, a lawyer and CEO of Sisters Inside; and Dr Andrew Binns, a GP at Jullums Aboriginal Health Service in Lismore whose duties include primary care for residents of Balund-a, a residential diversionary program for Aboriginal men located on a facility in the Upper Clarence Valley.

The two-hour forum was chaired by A/Prof Pauline Clague from the Jumbunna Institute at the University of Technology, Sydney. A wide range of issues was canvassed.

One of the broader concerns raised was the number of extra people for which the community will need to provide services, as health, housing, welfare and social services are already over-stretched. With an estimated 140 people to be discharged from the jail each month, and post-incarceration support often minimal, it is

feared homelessness levels will rise sharply along the North Coast.

Ms Kilroy told the forum there would be an influx of women and children moving to the Clarence Valley to support inmates. It's possible that upwards of 2000 women and children will be seeking affordable accommodation near Grafton, and with high rental costs and limited housing stock, this does not exist. Further, the distance from town to the CCC is a good 30-minute drive.

Ms Kilroy said in addition these families would be challenged by their own mental health and chronic disease problems, and their children will need to find school and, in all likelihood, additional support to successfully adapt. Most of these relocated adults would have problems finding jobs, further adding to local unemployment.



Awaiting inmates... new Grafton CCC under construction



“And when the state does not provide communities with the extra services they will need with a jail in the region it actually puts a strain on everyone and people become desperate,” she added.

“Sadly, Aboriginal women who are incarcerated don’t only lose their freedom but their children as well. The state normally puts their children into care.”

Ms Kilroy said Aboriginal women inmates rarely see their children as the state claims it doesn’t have the resources to organise jail visits.

“And later when the women want to regain custody they are told they have no relationship with their children. And this is due to the state refusing to facilitate family visits.”

Dr Binns described the new prison as “Like a big hospital with limited health services and lots of chronic disease, mental health problems and serious addiction issues.

“Getting GPs to come to rural areas is very difficult at the best of times. And to suddenly recruit a whole lot more will be a major challenge.”

He called the Balund-a facility “a farm with no walls, a diversionary facility that runs a wide range of programs for men over 18, concentrating on rehab.

“I think there should be more of these kinds of facilities for men and women in Australia so they wouldn’t have to build more jails. When someone is jailed they lose access to Medicare. The Justice Health and Forensic Mental Health Network runs health care within prisons, often providing minimal health care for people with serious health issues.

“Many will have infections such as Hepatitis C, which is now cured fairly easily with the right medicine. Blood borne viruses also occur at a much higher rate than outside. Injecting drug use without sterile needles and unsafe tattooing is known to occur widely in correctional facilities.

“And we see people with brain injuries from past trauma, including FASD, which results in problems in later life for these people. They often end up in the prison system and they should be getting care outside.”



Dr Binns told the forum that his current focus was on the lack of communication between health services inside and outside jails.

“Getting information about what happened to a prisoner inside is really difficult with Justice Health and I don’t know how it will be with Serco. We are investigating this through a committee at the North Coast Primary Health Network.”

The confidentiality, or some might say secrecy, around the prison and its accountability is a concern, with Serco having a commercial-in-confidence contract with the NSW government. Ms Kilroy said it was up to the community to keep the prison accountable.

“Don’t become part of the system and silence yourself. Expose them, challenge Serco and bring their activities out into the community so the community can do something. It’s essential to remain independent and speak truth to power. In Queensland, through intensive lobbying, we’ve managed to have two privately run prisons taken over by the state government.”

In March 2019 an inquiry prompted by the number of assaults on staff prompted the state government to take over the running of two high-security facilities, including the Southern Queensland Correctional Centre operated by Serco. The reason for the high assault rate was lower staff numbers, according to the Corrective Services Minister.

Professor Atkinson has worked in prisons running volunteer education programs for women, including in Alice Springs where Aboriginal women make up the vast majority of female prisoners.

There she started a Circle of Wellbeing program and worked with women who

were jailed for violent behaviours and were then locked into a circle of loss and grief and in immense pain.

“Every woman I worked with over five years finally disclosed sexual abuse,” she said.

“All the women without exception had stories of childhood that were so painful and shameful. In the town camps, and this abuse went back generations. The women had seen the massacres, we’re talking about intergenerational trauma.”

Professor Atkinson has the ear of magistrates and judges who have told her they’d prefer to sentence people to programs not prison.

“They said give us a program we can sentence them to, we don’t want them to go to prison. But where are programs we can send these women to?”

“Our system, our services are failing our women and the only way that the state can respond is do what it did in 1788, build more prisons.”

Professor Atkinson said Clarence Valley residents need to start thinking about setting up family healing centres and rebuilding community. Such a plan already exists. It was drawn up by her and others at a workshop and is in the hands of the Chair of the local Land Council.

“That family healing centre is critical for the Mums and bubs. There’s not much point in talking about what’s wrong with the prisons, because they are already there. We couldn’t stop them. But we can checkmate them.”

Further community conversations about the effects of the new mega jail and potential community responses are being organised.

# Justice Reinvestment reduces crime and costs

by Janet Grist

Justice Reinvestment (JR) is a strategy for reducing the number of people in prison by investing funds drawn from the State's Corrections budget into communities that produce large numbers of prisoners. JR suggests that money can be more productively spent through diversion of a portion of government funds earmarked for spending on prisons back into communities with high rates of offending and incarceration.

This represents a shift in spending, not an increase.

There were 13,475 people in NSW jails in March 2019, about 13% more than five years ago. Almost 30% of them are Indigenous. It is clear that the community would rather see money invested in diversion and prevention.

JR is a framework for action and argues that it makes little economic sense to continue to spend vast amounts of government money on prisons as a primary response to crime, other than in the case of more serious or dangerous offenders.

According to JR, imprisonment doesn't generally enhance the safety and wellbeing of communities, leading instead to increased rates of imprisonment. High rates of Indigenous incarceration occur at an inter-generational level within Indigenous communities and this cycle feeds the very same social problems which cause offending in the first place such as family and community fragmentation.

JR has been around in Australia for almost a decade and interest in it is growing. It is always community driven and place-based. In Australia, JR operates in NSW, Western Australia, South Australia, the ACT, Queensland and the Northern Territory under various organisations. It involves four main stages:

- 'Justice mapping' - analysing criminal justice data and cross-referencing this against indicators of disadvantage and available services
- Developing options for reducing offending and generating savings
- Implementing reforms, quantifying savings and reinvesting in communities. Reinvestment may include funding in anticipation of future savings; and



Northern Rivers resident, Fiona Allison is Chair of the Justice Reinvestment Network Australia (JRNA).

- Ongoing monitoring and evaluation.

Importantly, while JR may involve some reform of the criminal justice system it would also generally include introduction of culturally secure, community-based (and ideally also community led) strategies and programs to keep people out of the justice system as first or repeat offenders. For instance, programs that improve access to housing and education, that provide alcohol and drug rehabilitation or job training.

JR seeks to build the capacity of community to identify and take ownership of causes of and solutions to local criminal behaviour. In an Indigenous context, this approach provides an opportunity for self-determination.

JR also uses criminal justice and other data to determine how and where best to allocate public funds to reduce crime. It is JR's focus on economics, data mapping and place-based responses to offending that makes it different from other similar strategies.

Ms Allison describes her role as 'bringing together those interested in advancing JR in Australia' - including academics, key NGOs, and community members keen to see justice system and social reform.

"JR is growing all the time. It's about changing the way things work in and outside of the justice system to deliver better outcomes for local communities. And it's good to have a group such as Justice Reinvestment Network Australia (JRNA) within which to share ideas to achieve this. We work on policy reform too, advocating

for funding to set up a national JR body to coordinate work in this area. While JR is all about communities working things out on the ground, it would be great to have an overarching body like this," she said.

Ms Allison said JR was an approach that might be implemented by the community in the Clarence Valley.

"JR has great potential. Often people are really interested. They think it makes a lot of sense and it also now has a good track record in enacting change in various parts of Australia. But it's taking that next step. Communities think they need a big bag of money for JR, but work can start without funding. Having local leaders or champions of JR who will get things moving, start conversations about JR, will assist with this," she said.

Ms Allison said that given the massive investment of resources into penal responses in Grafton to what are effectively issues of social disadvantage, it would make sense to get JR up and running in the community alongside the jail. But only if the community is wanting to work with the framework.

"JR is about diversion but it is more than this. It also involves more than one organisation or one program. It involves collective action, and must also have a strong level of community buy in because it's a place-based, community driven movement. This is an essential component of its effectiveness."

Part of the JR approach is to reclaim data that is often gathered from a community (by government in particular) and then not fed back to community members.

"Through JR we access this data and pass it back to community to inform decision-making by the community. This is a powerful way for a community to empower itself and in the case of an Indigenous community, to get onto the path of self-determination."

Ms Allison said she'd be happy to address a community meeting in the Clarence Valley to talk about the JR approach if there was sufficient interest. She is also working alongside GPs sitting on the Primary Health Network's Clinical Council as they approach Serco and Justice Health for more information on what health services will be offered at CCC and how they will be run.

# NCPHN considers impacts of the new Clarence jail

**by Andrew Binns**

The soon-to-open Clarence Correctional Centre near Grafton is slated to be ready to accept prisoners by July 2020, however the preparedness of the system to accommodate inmates needs to be matched by the provision of essential community resources such as housing, and a proper assessment of the impact on local (and regional) health services beyond the prison walls.

As has been discovered elsewhere, this is a very complex social and public health issue. When it comes to health if there is one stand out issue of concern it is the interface between NSW Health, the funder of hospitals and justice and community health, and the federally funded Medicare system.

Adding to the complexity is that in NSW there are both State and privately run prisons. However the NSW Justice Health and Forensic Mental Health Network that manage prisoner health also have a monitoring role within private jails, including medical records being handled by their software and stored on their data base.

When it comes to clinical handover of care for prisoners after their release, ideally the system should be similar to a patient being discharged from a NSW public hospital. The NCPHN is working with the NNSWLHD and has put a lot of effort into improving this clinical handover of care to GPs, with great success.

Unfortunately this is not the case with clinical records collected in jails. There are barriers and delays with these being handed over to GPs and mostly a proper transfer of clinical care does not happen at all.

This results in unnecessary duplication of pathology and radiological testing, which is a burden on the cost to the health system, and frustrating to both clinician and patient. It can also be risky, with a GP being unable to continue the care with confidence without timely access to important clinical information.

**THE NEW JAIL:**

- Inmates: 1700, 1000 of them in maximum security**
- Inmates released each month: 140 – more than half expect to be homeless upon release**
- Staff: 600**
- Serco contract: \$2.6bn over 20 years**
- Cost per prisoner per day: \$292**

Information from Infrastructure NSW and the Deloitte Consulting report on impacts of CCC



Lavidia, 27 kms from Grafton

Could the use of the My Health Record (MHR) help? Under the current system the answer is ‘no’. This is because the doctors working in jails are unable to access these MHRs records as prisoners don’t have Medicare access.

Australia lags other developed countries in justice health and there are plenty of models overseas where the health of prisoners is better managed. Scandinavian countries stand out in their approach to this issue.

The NCPHN Clinical Council is approaching these issues in three ways.

1) Improving the clinical handover of patient care between NSW jails (whether Government or privately run) and GP primary care services following release from custody.

2) Looking at ways of diverting offenders who have significant mental health problems or cognitive impairment away from incarceration towards rehabilitative treatment programs.

3) Exploring better follow up of GP services to residents using telehealth consultations to this remote site.

All these measures will need funding but potentially there would be significant cost savings to Corrective Services NSW and the health system, State and Federal.

There is goodwill within the NSW Justice Health and Forensic Mental Health Network to work with the NCPHN Clinical Council to improve the situation regarding clinical handover.

However, at some stage there needs to be goodwill coming from the Federal Government in addressing the use of the MHR in jails to improve communication of medical records between health providers. This is a political matter but now is the time for this to be addressed.

A proper system would be for the betterment of prisoners’ health and, in all likelihood, contribute to reducing recidivism. In turn this would lead to dual cost savings for both corrective and health services.

# Let's stay Sobah...

by Rachel Guest

**Let's stay Sobah... How a non-alcoholic craft beer helps us enjoy a healthier life.**

Dating back to the First Fleet, Australians and alcohol have a long and storied relationship. The 2019 Annual Alcohol poll found 79 percent of Australians who consumed 6 to 10 standard drinks on a typical occasion considered themselves responsible drinkers, as did 64 percent of Australians who drink to get drunk at least twice a week. The Foundation for Alcohol Research and Education chief executive Michael Thorn said the nationally representative online survey confirmed once again that, "Australia has a problem with alcohol".

Although, still largely Australia's drug of choice, on the flip side of the coin, some Australians are beginning to question the role of alcohol in their lives. According



Clinton Schultz

to Drinkwise, 20 percent of Australians abstained from alcohol in 2017, an 11 percent increase from 2007.

One such ex-drinker is Clinton Schultz. The motivation to ditch the booze was a simple one for this father of two -- an earnest request from his kids to give up the "silly drink". Although Clinton never felt his drinking was out of control, understanding that giving up alcohol was highly likely to make him a more present, healthy, and energetic parent was enough to kickstart his sobriety journey: "I decided to go completely sober for family reasons. For me, that was enough reason to give up drinking."

Six years later, Clinton hasn't touched a drop. While it might've been fatherhood



that motivated him to live a sober lifestyle, it was a lack of beer alternatives that inspired him to create Sobah - 'sober', get it? - Australia's first non-alcoholic craft beer. Immediately recognizing that there were no options that brought the same feeling, flavor and ritual of a good craft beer with mates, Clinton decided to make his own: "I was frustrated with there being nothing available, so I started making stubbies that I'd want to drink."

He landed on an IPA, a lager, and Pilsner. Clinton, who is also a chef and Gamilaroi man, began selling his brews from his Burleigh Heads food truck.

"Our food truck was doing all native produce and Aboriginal inspired food. As all of our Sobah beers are infused with bush tucker flavors, it was a natural melding of the two."

It was a hit and soon locals were demanding take home cases. "People began asking if they could grab takeaways. We literally had people coming with growlers and filling them up."

Sobah has grown in popularity, as more people have become "sober curious" -- a pop culture term that refers to people experimenting with dry periods. Clinton explains that this group makes up his biggest market share.

"Most of the people who drink Sobah, are not sober. They're usually looking for an alternative for reasons from pregnancy, to being a designated driver, Dry July, or perhaps chronic illness."

In terms of age demographics, Clinton says that Sobah appeals to those at opposite ends of the spectrum.

"At one end you have the Baby Boomer generation that have probably consumed alcohol for the majority of their lives, and due to health reasons are looking to cut back their drinking and extend their longevity. On the other end, you have young people who are choosing to live more health-focused lives and abstain completely. Having said that, even those young people who are drinking alcohol do so in a far more conscious manner than my generation."

When asked what he thinks are the biggest hurdles for people looking to make a change, he says, "Social pressure, by far it's social pressure. Particularly in Australia, there's an unhealthy attachment between socializing and alcohol consumption."

Obviously as a man who has walked the path from social drinking to social sobriety himself, Clinton understands first hand the challenges of giving up booze. "People find that when they choose not to drink, their social circle does diminish. For me, almost 95 percent of my friend group dropped away."

Clinton was passionate about ensuring giving up drinking didn't lead to social isolation. At the same time, he understood the difficulty of being at a bar and feeling like an outcast,

"It's very difficult for people to be at a bar and not have a drink in their hand. So with



Sobah, we're trying to fill that gap by giving people something that can put them at ease without feeling pressured to have alcohol."

Curious to know if people had found Sobah to be a tool to help them through challenging situations, Clinton responded, "At least weekly, we've someone write to us telling us that Sobah has assisted them make better choices."

However, being advocates for sobriety is most definitely not the intention of the brand: "We're not out to promote sobriety. We're out to help people think about the choices they make and to have an option available for whatever reason and at whatever time they choose not to drink".

As Clinton surmised perfectly, "people make better choices, when there are better

choices available."

As demand has risen, so has Sobah's distribution. Since its inception Sobah has expanded from its Gold Coast headquarters to hundreds of independent retailers in every state and territory. Looking further abroad, even UK giant, Tesco has flagged interest in stocking the line.

Although Clinton is thrilled with the growing interest in Sobah by local independent retailers and punters he has faced struggles in getting Sobah into Australian supermarket chains and restaurants and pubs (especially on tap - prized beer real estate). Even with such progress, it seems that as a nation a "sober night out" is a long way off from being the norm.

However, the fact that people are starting to question their consumption of alcohol, is definitely something worth celebrating, perhaps with an ice cold Sobah Pepperberry IPA.

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# Clinical Councils seek action on “climate emergency”

The North Coast Primary Health Network’s three Clinical Councils have asked the federally-backed body’s senior management, along with the heads of the region’s two Local Health Districts, to place more emphasis on the “energy and environmental sustainability of health-care-related activity”.

In a recent letter the Hastings Macleay, Mid North Coast and Northern Clinical Councils acknowledged work to date on enacting sound policies – for instance, the Mid North Coast LHD’s Energy & Environmental Sustainability project has



included the installation of extensive solar panels at Port Macquarie Base Hospital, saving \$1/4m in two years.

However, the Clinical Councils spoke of a “climate emergency” and said they “wish to do more to both support and be supported by our state and federally funded health organisations”.

The aim is to “more effectively reduce the deleterious effects of human activity on the environment upon which we depend for our well-being.”

Adding, “It is now abundantly clear that human activity is having a deleterious effect on the biosphere” – a view yet to be endorsed fully across government – the coalition said, “Health care itself has a significant carbon footprint... The consequent effects on the health of individuals and communities are reinforced physically, emotionally and economically... We would like to be able to make better choices, more easily when it comes to the environmental impacts of our actions.”



Bushfires destroyed this house in the Northern Rivers.

On a practical level they noted that, “Hospital avoidance reduces carbon emissions, since hospital and ED stays produce lots of carbon” and advocated an increased use of telehealth by specialist and GP services to reduce transport emissions.

The Councils are in the process of establishing Sustainability sub-committees and hope the health-coordination bodies will nominate representatives.



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## Vale Albert (Digby) Moran (1948-2020)

The most public, hence most viewed, work by the late Albert (Digby) Moran spans the facade of Woolworths River Street, Ballina store. The work, or more accurately works plural, as the materials used are quite different, is made up of a painting, *Floating Through My Spirit Home*, affixed to a large, eye-level glass window, and panels of drilled corten steel\*, *Someone's Always Watching You*, translated from Digby's cloth paintings.

Inspired by the Bundjalung side of his heritage and nearby Cabbage Tree Island where he grew up, the works were an innovative commission by the supermarket in 2014. They will remain here in



Bundjalung artist Digby Moran with Lismore Flood, one of the highlights of his recent 'Growing up on the Island' exhibition at Lismore Regional Gallery.

he began focussing on imagery from his Bundjalung culture, stressing that his inspiration was strictly local – “I have always been a saltwater man” – and he would not appropriate images such as barramundi or crocodiles held sacred by other Aboriginal groups.

The popularity of his work soared, locally, nationally and further afield, notably Germany where a number of successful exhibitions were staged. In Lismore, one of the towns he called home, Digby was well supported by collectors as well as Lismore Regional Gallery where, in late 2019, his show 'Growing Up on the Island' received great acclaim. This was covered in **GP Speak**.



perpetuity, a short walk from the Richmond River that figured so prominently in the artist's life. (Another large work adorns the Goonellabah Sports & Aquatic Centre).

While Uncle Digby may have been destined to become an artist he was certainly not born to the occupation. He left 'Cabbo' at the age of 16 to work in the local cane fields, making a radical career change

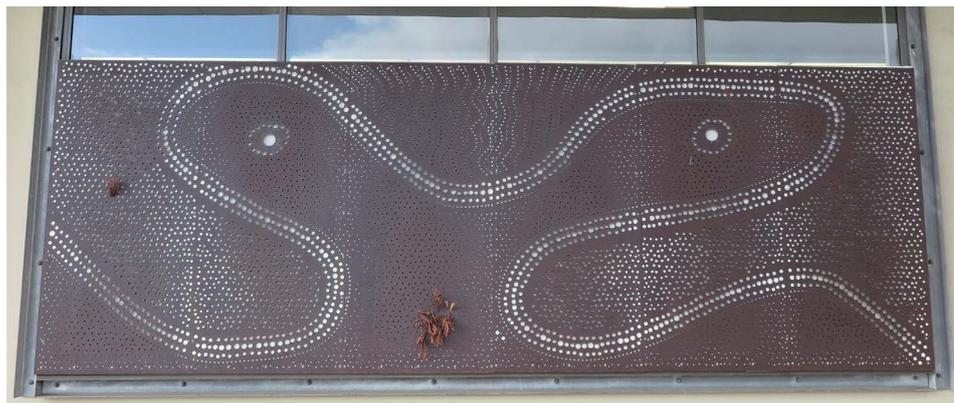
a few years later by joining the legendary Jimmy Sharman's boxing troupe, walking in his father's footsteps.

The troupe travelled to shows all over Australia, but the lifestyle, fuelled heavily by alcohol, got on top of him and at the age of 42 he quit drinking and in 1991 he enrolled in an art course at TAFE.

Uncle Digby's talent quickly emerged as

After many productive years of painting and mentoring aspiring young artists Uncle Digby died in mid-January at the age of 71. We offer our condolences to Uncle Digby's partner Kerry Kelly, his children, grandchildren and other family members and friends.

\*Corten or weathering steel is a group of steel alloys developed to eliminate the need for painting, which forms a stable rust-like appearance after several years' exposure to weather.



Happy Times (detail), 2018, acrylic on canvas, Photo: Linda Cunningham

## Byron's blue waters beat the pool's black line

by Daniel Bills

The routine is monotonous but, somehow, part of the appeal. The alarm sounds at 4.45 am and I swing my legs from under the covers, and guide them onto the floor boards, the only clue as to the season. The ritual continues... feeding of animals, breakfast and coffee, the goal being to exit the the garage at 5.15. The journey is invariably notable for the lack of recollection, with arrival at the pool being the first stable memory of the still-young morning.

The next is the cool of the water as it rushes over my skin, focusing my attention on the present.

I was always something of an "aquanaut", a competitive swimmer in my early teens before playing waterpolo for the Victorian junior team, representing USyd at the University games in water polo and being selected in the Universities' Green and Gold side.

But then somewhere in the melange of training, work, and life at large my love of the pool slowly evaporated. Whilst playing waterpolo I continued swimming but its rewards had disappeared. Then, five years ago, I started a comeback of sorts, swimming at Lismore baths with a local coach.

I vividly recall swimming 300 meters, hauling myself on to the lane rope and exclaiming that I would never again let my swim fitness lapse, although as anyone who has ever trained for swimming knows, the monotony of the black line is enough to drive one almost insane... up and down, struggling for breath, dragging yourself through a progressively more viscous fluid at an hour when few had even struggled out of their crib can lose its appeal quickly.

Enter ocean swimming, a concept that instills fear into the hearts of many but for those who indulge the rewards are plentiful.

My first ocean swimming experience was as a young boy swimming in the Pier to Pub race in Lorne, Victoria. My only recollection of the whole experience was profound hypothermia. Hardly a memory that would lure someone back to the ocean.



Despite my previous experience I jumped at the chance to swim with my then-coach in Byron Bay. For those oblivious to this unique group of athletes the Byron winter whales are a group that swims every day of the year, usually leaving from the Byron Bay surf club at 8.00 am. This group of kindred spirits shares the love of ocean swimming but represents a tapestry of society. Male and female, working professionals, retirees, visitors, the young and the not-so, the physically and mentally fit. It's a ritual and one that will take place in reverse in an hour or so's time.

Swimmers meet on the decking at the club for some light chat before the body's coverings are shed – the great equaliser – and en masse the school (collective for ocean swimmers) take to the beach and begin the walk east up the beach to respective take-off points.

Herein lies what my journey has taught me. As I have aged paying attention to my mental health has become an active process. This walk along the water's edge is a process of mental cleansing. This time allows swimmers to chat, meet, develop friendships, solve the worries of their various worlds.

It would be fair to say that I have made some of my closest friends en route to Wategoes Beach. I have found clarity in situations which I had thought unnavigable. Felt a sense of camaraderie and kinship, allowed feelings of solitude to

dissipate.

While in pool swimming the the black line acts as a hypnotic, meditative visual, with the rhythmic pattern of breathing leading to a state of transcendence. The contained environment cannot compete with the great outdoors, not least the natural beauty of Byron.

On a good day the water at Wategoes has a clarity that enables the swimmer to see for metres, and when that world opens up it is quite a special moment. The surging sea lifts the swimmers one by one and the intermittent breaking of the waves sees members of the group duck-diving for the safety of the ocean below the white foam. The reef and schools of fish all dance to an individual rhythm.

The first 400 meters of a typical swim takes us to the Pass where the sea here is usually calm, with a gentle undulation of distant waves as they flow by en route to entertain the surfing masses riding boards. It is here when encounters with turtles, perhaps rays, and even shovel nose sharks or wobbegongs are common. It is amazing to be mindlessly swimming along and suddenly swim over the top of a turtle or find yourself in the middle of a school of fish.

After what would have to be the highlight of any swim from Wategoes to Byron the race is now on in earnest back to the surf club, with the master tacticians plotting



their approach, competing in good spirit with the coast huggers, those who choose to swim straight across the bay, and all routes in between. The variety of paths taken is reflected by the individuality of those who practise this religion. Some swimming with friends, stroke by stroke, others engage in a solitary race to the showers at the front of the surf club overlooking the magnificent bay.

When we all catch the final wave into shore the sand rises to greet our bodies, contacting with the real world that awaits



on the beach... the backpackers, couples, families, others savouring their own version of Byron's scene.

The crew seek out towels and slip back into the pre-swim attire, transformed back into land creatures, until the next time. Tales are shared about wildlife sightings, who swam well, what courses were taken, the weather conditions, chop, temperature, weed, stingers and, most importantly, when we will all be back to do it again.

The final piece of the therapeutic episode is the almost mandatory post swim coffee and debrief, little more than a rehashing of all the stories told since that final wave.

In the way that the ocean is constantly changing no two swims are ever the same, and that's why I think we all keep coming back. It's for the surprises, the pleasure and the pivotal role ocean swimming plays in our physical and mental wellbeing.



Dr Daniel Bills MBBS BSc (Hons) FRACS is a Colorectal and General Surgeon based in Lismore and Ballina. Following a first-class honours science degree at Monash University he graduated from The Sydney University School of Medicine in 2001. He received his fellowship in general surgery in 2008, going on to complete a colorectal fellowship in minimally invasive colon and rectal surgery at the John Flynn Hospital in 2010.

He has held academic posts with Bond, Griffith and Monash Universities and is a current foundation member of the Royal Australasian College of Surgeons Academy of Surgical Educators.

In addition to his work in minimally invasive colorectal surgery, he treats a range of general surgical conditions such as Skin Cancers, Hernia and Gallbladder and performs investigative endoscopy.

Photos of Dr Daniel Bills by photographer Dave Gleeson [surfshots.com.au](http://surfshots.com.au)

One of the other ocean swimmers (shown left) at Cape Byron Marine Park.

Photo: © John Natoli



Book Review

by ROBIN OSBORNE

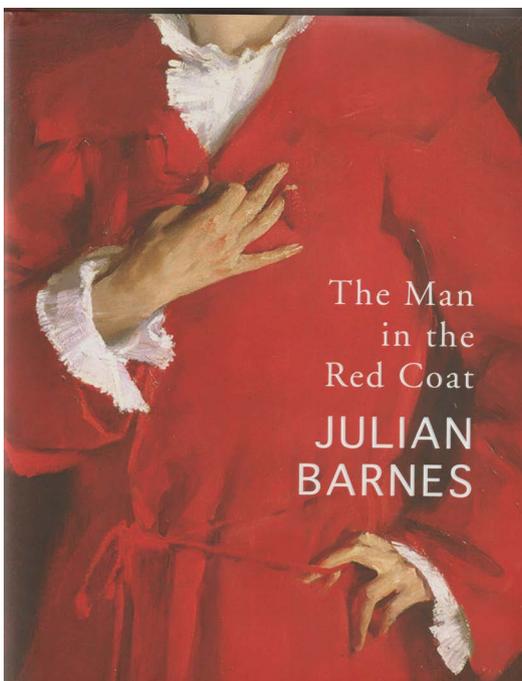
**The Man in the Red Coat**

Julian Barnes  
Jonathan Cape 263pp

This learned and beautifully produced book delivers the story of Dr Samuel Pozzi, a pioneering gynaecologist, and two fellow bon vivants, into the hands of one of the finest contemporary novelists. This is Barnes' eighth foray into non-fiction, helped by a heaven-sent character and a time in history, the Parisian Belle Epoque, when almost anything went.

The tale begins in the mid 1800s when what Barnes dubs a "strange trio" embarked on what they called an "intellectual shopping trip" to London. While luxury shopping was undertaken, and museums visited, carousing and debauchery were more often on the agenda.

The tale oscillates between the capitals of France and England, more often the former as the author explores the mores and social connections of the period, helped greatly by his passion for the French language and Gallic ways, which led to his being awarded the Legion d'honneur in 2017.



Pozzi the urbane figure... the Darwinist, the scientist, the modernist... Pozzi, a sane man in a demented age."

However, his travelling companions to London were anything but sane: Prince Edmond de Polignac and Count Robert de Montesquiou-Fezensac conducted themselves more like teenagers at schoolies, one of them an outrageous homosexual.

Nor did Pozzi hold back, being aware of his charm, excellent English and great attractiveness to women, yet "there was, for almost his entire life, very little scandal attached to Pozzi's name. His activities were heterosexual, legal and (as far as we know) consensual... there is not a single recorded note of female complaint against him."

Just as well because back in Paris he was soon "transforming French gynaecology from a mere subdivision of general medicine into a discipline in its own right," and in 1890 publishing his 1110-page Treatise that won international fame and celebrity patients. It would remain the standard text into the 1930s.

During WW1, in a handsome uniform (of course) Pozzi became deeply involved in the theory and practice of war wounds, while continuing to collect antiquities and garnering praise for long-distance consultations, including for Sarah Bernhardt who called him "Doctor God". Near war's end Pozzi was shot by a former patient for whom he had conducted a scrotum procedure. The patient then turned the gun on himself.

Pozzi underwent surgery, specifying the anaesthetic he desired – "enough to nullify the pain, but not enough to put him out. And so he is present at, and fully aware of, the last laparotomy he will attend in his life."

No novelist, even a fine one like Barnes, could invent such a tale and again we see how fact can be stranger than fiction.

This is not just a book for Francophiles, and indeed it is hard, initially at least, to believe it has a grain of truth. Then we are introduced to the cropped cover painting by John Singer Sargent, which the author encountered in the National Portrait Gallery in London, on loan from America.

The title of the elegant 1881 work is Dr Pozzi at home, "painted in the late mornings," we are told, "after which artist and subject had lunch together... It is all highly theatrical: there is swagger not just in the pose but in the pictorial style."

To say there was swagger in the life of Dr Samuel Jean Pozzi, born a commoner and destined to become "a society doctor, a book-collector, and a generally cultivated conversationalist", would be a massive understatement. Think a heterosexual Oscar Wilde possessing exceptional skills with the scalpel, a wealthy womaniser who mixed in the circles of Proust, Henry James and Collette, and who stood up for Dreyfus when to do so attracted opprobrium.

All this made Barnes become "less interested in Pozzi the amorist, and more in Pozzi the fraught family man, Pozzi the ever-curious doctor, Pozzi the traveller,

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# Australian Health eCommunication - a short primer

by David Guest

**Muḥammad ibn Mūsā al-Khwārizmī** (محمد بن موسى خوارزمي) was a mathematician and head of the library of the House of Wisdom in Baghdad in 820 CE. His book on calculations gave us the word algebra and his name lives on in the term algorithm.

An **algorithm**, as defined in Wikipedia, is a “finite sequence of well-defined, computer-implementable instructions, typically to solve a class of problems or to perform a computation. Algorithms are always unambiguous and are used as specifications for performing calculations, data processing, automated reasoning, and other tasks”.

The **RSA** (Rivest–Shamir–Adleman) algorithm is used for encrypting and decrypting messages. A user creates two paired keys, a public key that is widely disseminated to those with whom you may want to communicate securely and a private key, that you unsurprisingly keep to yourself. In simple terms the way it works is that one of the keys locks the message and only the other can unlock it. Its practical use is to allow the sending and receiving of secure, authenticated messages.

The RSA algorithm was first described in 1977 and came into widespread use in the late nineties. It was **embraced by the Australian government** in the 2000s and the **HealthCare Public Directory** was established as a repository for government authenticated public keys of health professionals. You can send an encrypted email to any person in the directory and be sure that it will be secure and the recipient will also be assured that it came from you. If you search the directory for yourself your public key will be displayed ... or it may not.

If it is displayed, others in the directory can send you a secure message and you can decrypt it with your private key. Medical practitioners will recall their private key that was sent to them in the mid 2000s on a plastic card that plugged into the computer. Unfortunately not many GPs still keep that plastic card handy and the email you will receive will be all “gobbledygook”.

So what went wrong? To the designers and implementers of the system the answer is users; to users it is the design and



implementation of a system that did not mesh with their work flows. It was a mess and failed.

Nevertheless the need for the secure transmission of medical data between health professionals remained. Large pathology companies implemented their own systems and smaller companies use one of several **secure message delivery (SMD)** companies.

Since point to point communication from practitioner to practitioner had failed, the solution was to enable secure communication from entity to entity, from one practice to another. The secure SMDs managed the whole pipeline from the generation of keys to the acknowledgement of successful delivery of the message.

It all worked seamlessly if you were all with the same SMD but communicating with doctors who were on a different system required each SMD to implement gateways to the others. This involved overcoming significant implementation barriers but more relevant is the fact that there were no strong financial incentives to provide interoperability and considerable business reasons for each SMD to maintain their own walled garden. We were yet again at an impasse.

The Australian government, like other governments around the world, has never been very keen on privacy. They are keen on encrypted communication between two parties but only with the proviso that they can be a silent third party in any electronic health communication. Despite the government’s protestations such backdoors are by definition insecure.

As a consequence, the government has mandated the use of the government public key infrastructure for a **valid Medicare referral** since the start of eReferrals in the early 2000s. As noted above this failed but the government did not care until the advent of the Personally Controlled Electronic Health Record, now known as the My Health Record (MHR). It was great that 20 million Australian each had a slot in the MHR but not so good that they were all empty.

The solution for the MHR was to make the upload of curated medical documents easier and not rely on GPs performing a separate authentication step. GPs could authenticate in their own electronic health record (by logging on) and then the practice would use the government issued keys (certificates) to communicate securely with the MHR. Following some financial incentives to general practices the number of active MHRs had reached 6.45 million by January 2020.

This, however, raises the issue of the validity of the **Medicare eReferral framework**. If GPs don’t have to personally authenticate with government issued keys for upload to the MHR, why can’t they send a secure eReferral to a specialist via a similar process?

This issue remained unresolved for seven years until the Department was pushed in 2019 by GP and digital health expert Dr Oliver Frank to answer the question. After lengthy correspondence **Dr Frank received the following:-**

‘It is sufficient for an email referral to

cont on page 18

# Australian Health eCommunication - a short primer

cont from page 17

simply state that it is “signed electronically by [provider name]”. However ... such an electronic signature will only be effective if the person receiving it (in your scenario the specialist) accepts the signature in that form.

‘Some specialists may insist on hardcopy referrals or some patients may be advantaged by having a hardcopy referral that can be taken to their choice of specialist.

‘But, unless there is something unusual, specialists are likely to accept email referrals from GPs, particularly in circumstances where such arrangements

have been trialled and no problems have come to light.”

The SMD provider Medical Objects has elaborated on these arrangements in a post on their website, [Sending e-Referrals With or Without the Individual PKI](#). They state they satisfy DoHA and Medical Australia requirements and it is:-

“accepted that the referrer can sign the referral with an organisational certificate with the ability to identify the individual through local audit logs for the purposes of auditing, and this was supported for the current and interim state”.

These statements have been embraced by many GPs and specialists around the

country. It is reported that over 70% of doctor to doctor communication on the Gold Coast is by electronic communication only. On the North Coast the figure is thought to be less than 30%.

The **death of the fax machine** has been long touted in medical circles. We have now reached the stage where turning off the fax machine is becoming a viable option. The only task that remains for the busy GP is working out which specialist still wants a paper copy or, if she is happy to receive an eReferral, which secure message delivery provider she uses.

Such is progress.

## Hats off to a North Coast icon

by Robin Osborne

Whether due to our increased sun awareness or a notable rise in “fashionalism” – which sees MPs from country and city alike sporting R M Williams boots – the Akubra hat is now covering more heads than ever before. In fact they’re so popular that anything apart from a standard style and colour will entail a three-months order wait, not that off-the-shelf options are lacking in choice.

The leading local Akubra stockist is George Gooley Menswear with shops in Lismore, Ballina and Casino. The business is headed by Peter Gooley who says sales of the iconic headwear have risen dramatically in recent times.

No newcomer to the Akubra game, Peter has been selling the brand for the past fifty years: “The most popular style remains the Cattleman,” he told GP Speak, “followed by the Roughrider. But if that suggests most Akubra buyers are farmers, think again. The hats have become increasingly popular with younger people, male and female, and the various styles and colour combinations are almost infinite.”

If you’re prepared, to wait that is.

Peter Gooley estimated that the business sells around 80 Akubras a week across its three main shops, a healthy trade but

hardly a dent on the 1500 hats they keep in stock.

“A few years ago we kept nothing like that, just one rack of them. If someone had suggested how popular they would become I wouldn’t have believed them.”

Right on cue, a customer came into the Lismore store and picked out a handsome new... Akubra.

Local sales are greatly outstripped by the national market, not least a long-term contract signed by Akubra in 2015 to supply 21,000 ‘slouch hats’ to the Australian armed forces. An Akubra forerunner company launched in 1874, with the Akubra brand itself dating from 1912. For a time the firm had the rights to make and market the American cowboy brand, Stetson, but Akubra was more popular and the firm now exports to the US market.

Factory locations have included the foundation site of Hobart, then Sydney and from 1974, the Mid North Coast town of Kempsey where the business is still headquartered.

One thing that has not changed over



Joanne Hourigan and Peter Gooley from local Akubra stockists George Gooley Menswear. Photo by Robin Osborne

time is the raw material required to make an Akubra, not something to please animal lovers - rabbit fur. The process, which takes around six weeks, dates from the late 19th century when the pelting process was perfected.

A 1950s ad proudly claimed that, “All Akubra Hats are made from Pure, Long-matured Australian Fur by highly skilled craftsmen.” In those days a new Akubra cost around £1.00. Now they’re just shy of \$200, and while the manufacturing is more sophisticated and the rabbit fur is mostly imported (from Europe), nothing has rendered this legendary product any less desirable to new generations of hat wearers. Indeed, the Akubra is more popular than ever.



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## Beyond Paper Clips



by David Guest

Medicare, the government voucher system for out of hospital medical services, is now 36 years old. It has enjoyed widespread support over that time and, while opposed by the medical profession initially, and certain politicians since, albeit not publicly, it has become accepted by health professionals and the general public. For many Australians it is the only system they have ever experienced.

Medicare is similar to other national health schemes found in the developed world and while most agree it is not perfect they are glad it is not what we see in the USA.

This model of government financing the medical sector has in recent years been extended to aged care services, disability care, and mental health support. The government offers packages of care in a competitive market for contractors to supply the designated services to clients.

Contracts are awarded to large organisations that are incentivised to employ staff with minimum qualifications for fixed periods of time. The focus is on doing the minimum required in the shortest period of time to meet the requirements of the contract. Fast and cheap! (**See Good, Fast, Cheap - Pick Any Two**)

Since the contracts are usually specified for a short period of time there is no long-term security for the organisation or the staff. For those on the bottom ranks of the organisation the lack of security in these arrangements is quite stressful. Those at the top have more options to use their skills to find employment in other areas. However, in both cases, there is no long term commitment to the organisation or its activities.

*“Commissioning creates its own series of problems... any solution will recognise the value derived from a skilled workforce efficiently caring for their charges” - The King’s Fund*

Late last year the **Royal Commission into Aged Care Quality and Safety** released its interim report. Its title, *Neglect*, summed things up. The issues for patients and their families in negotiating the My Aged Care system’s enrolment process, access issues

and quality of care are well known to GPs.

The constraints placed on Aged Care staff were examined in detail by the Commission, which noted in its introduction:-

“We have heard about an aged care workforce under pressure. Intense, task-driven regimes govern the lives of both those receiving care and those delivering it. While there are exceptions, most nurses, carer workers and allied health practitioners delivering care are doing their best in extremely trying circumstances where there are constraints on their time and on the resources available to them. This has been vividly described by the former and current aged care staff who have given evidence.

“The aged care sector suffers from severe difficulties in recruiting and retaining staff. Workloads are heavy. Pay and conditions are poor, signalling that working in aged care is not a valued occupation. Innovation is stymied. Education and training are patchy and there is no defined career path for staff. Leadership is lacking. Major change is necessary to deliver the certainty and working environment that staff need to deliver great quality care.”

The government’s preferred model of market forces maximising the outcomes also came under criticism by the Commission. The lack of data about current practices and performance turns selecting a provider into a lottery.”

The report concluded that,

“The structure of the current system has been framed around the idea of a ‘market’ for aged care services where older people are described as ‘clients’ or ‘customers’ who are able to choose between competitively marketed services. But many older people are not in a position to meaningfully negotiate prices, services or care standards with aged care providers. The notion that most care is ‘consumer-directed’ is just not true. Despite appearances, despite rhetoric, there is little choice with aged care. It is a myth that aged care is an effective consumer-driven market.”

Late last year the **Productivity Commission’s Draft Report into Mental Health** was also released. Although somewhat less critical than the Aged Care

Commission of current arrangements, it too highlighted the uncertainty relating to short term contracts and recommended that the minimum contract length be increased to five years.

This recommendation was echoed by the **NSW Mental Health Coordinating Council Workforce Survey (2019)** that found nearly half of all community mental health workers were on short term contracts or were casual employees. The survey recommended further analysis of the industry with particular attention being directed to the effectiveness and training of the workers.

Such issues are not unique to Australia. The UK’s National Health has long championed the commissioning of health services and general practice care and has often served as a model for such approaches in other countries. The commissioning framework undergoes constant change with various programs designed to improve care.

The King’s Fund, an independent organisation that monitors health care in England, recently reviewed **the difficulties Primary Care Networks face** in caring for their elderly at home and found that the greatest challenges were in maintaining a skilled workforce. They stated:-

“Community services have seen some of the sharpest reductions in staff numbers in recent years, including among community nurses. Put simply, these standards cannot be achieved without the staff to deliver them.”

Governments around the world are under increasing pressure to provide services for their aging and infirm populations. Commissioning is a vastly more efficient method of addressing these issues than the government running the services directly themselves. Nevertheless commissioning creates its own series of problems that need addressing and any solution will recognise the value derived from a skilled workforce efficiently caring for their charges.

Humans are complicated and caring for them requires a range of skills. Solutions to look after them will need to move past the “paperclip” approach.

# Lismore reaches its million-dollar milestone

Few, if any, living Australian artists are selling works for one million dollars, but then how many spend more than six years to see their creations come to fruition?

These factors alone make the Hannah Cabinet, the masterwork of local cabinet-maker Geoff Hannah, truly unique. On top of that come various details of the work: 92 drawers, 34 types of timber, four rare species of shell and 17 types of precious and semi-precious stones.

Less visible to the naked eye are the secret drawers, one of which holds a swatch of fabric from Marie Antionette’s boudoir – as part of his Churchill Scholarship Geoff travelled to Europe and was made privy to the fabulous furniture at the Palace of Versailles where even the restorers were impressed by his skills and knowledge. The fabric was a parting tribute to his expertise.

Geoff was made an Honorary Fellow of



Southern Cross University in 2009 and was awarded an OAM in 2018 for services to the visual arts. Other works include a cabinet displayed at the Governor-General’s residence in Canberra.

The last step on the Hannah Cabinet’s journey remained uncertain until recently

when a massive fundraising effort, boosted by the NSW Government but mainly achieved through private donations, reached the \$1m mark and ownership of the work was secured for Lismore Regional Gallery.

Fundraising team member Brian Henry, a former Lismore mayor and a cabinet making student of Geoff Hannah, said that to his knowledge it was the first time a piece of art valued at \$1m would be on permanent display in regional Australia.

So this is a million dollar milestone in every sense, but not, Geoff stresses, a pathway to his retirement. He will continue to press ahead with other artistic projects and mentor a stable of students whose creations, as a recent exhibition showed, have every chance of becoming million dollar men and women in coming years.



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## Theatre riches coming to us soon

Spearheaded by high-profile professional productions from the NORPA company, starting with comedian Jonathan Biggins' acclaimed *The Gospel According to Paul* [Keating], this year's show season in the Northern Rivers is shaping up as the best ever. Highlights range from *Priscilla; Queen Of The Desert* (with a live band) and *Mamma Mia*, both by Ballina Players, to Lismore Theatre Company's *Educating Rita* at the newly upgraded Rochdale Theatre in Goonellabah.

Hot on the heels of Biggins' one-man show comes Ballina Players' *Dial M for Murder*, the inspiration for the 1954 film directed by Alfred Hitchcock, and an ideal piece for live theatre. The Swift Street theatre's table configuration is ideal for an informal night out (or matinee), with wine and other refreshments available, and shows book out quickly.

Last year's season ended with an excellent production of the musical *Wicked*, *The Untold Stories of the Witches of Oz*, with three GPs in the cast (Luke Hogan, strutting his stuff in fetching tights, and Ann Staughton and Laura Taylor in the ensemble). The volunteers who keep this company running so well include Warwick Binney, whose family funeral business in Lismore is well known, and Jacquie McCalman whose husband Craig is an anaesthetist and ICU specialist in Lismore.

Lismore Theatre Company is facing a big 2020 in the freshly painted and refurbished Rochdale Theatre, according to its president and frequent performer, Sharon Brodie: "I am so happy that our beautiful theatre has had this make-over. We love this place that creates wonderful theatre and connects our community. It's also perfect timing as we approach our 50th anniversary later in the year."

LTC received a grant of \$29,123 from the State Government's Create NSW and, together with \$7000 from Lismore City Council and \$6000 of LTC's own funds, a total of \$46,883, including in kind contributions, has been spent on the refurbishment of the theatre.

The grants funded the installation of air conditioning in the auditorium and the supper room, repairs to the vintage red brocade raked seating and painting of the



Ballina Players production of 'Wicked'

building. To complete the works, new signage and a new roof are being added.

Sharon said, "The first show for the year, the fabulous *Educating Rita*, opens on March 20. Rehearsals for that show and the pantomime *Puss in Thongs* to be staged in the Easter school holidays are now so much more comfortable with air conditioning."

The not-for-profit NORPA needs little introduction, having been established through the enthusiasm of now-Opera Australia head Lyndon Terracini and a team of theatre-deprived volunteers more than 20 years ago. Productions over the years have included some of Australia's best touring acts, such as Bangarra, Robyn Archer and Bell Shakespeare Co.

Now well established at the refurbished Lismore City Hall, with outreach shows in community settings, NORPA's annual season is an event in itself. This year includes the 91-Storey Treehouse, US alt-country superstar Patty Griffin, *Animal Farm*, some top-notch physical theatre and an original show from Yaegl Country.

We are now being offered shows of a standard the area deserves, and sincere thanks are due to the many dedicated volunteers, both on-stage and back-of-house, whose efforts make this possible.

Certainly, let us continue to enjoy Netflix, Stan etc but do run your eyes over the offerings from these theatre companies



Jenny Dowell as Clairee (left), Sharon Brodie (centre) as Ouiser and Elyse Knowles as Annelle in LTC's production of *Steel Magnolias*

and see what might appeal for an enjoyable and convivial night out. You won't be disappointed.

Information and bookings –

[www.ballinaplayers.com.au/bookings](http://www.ballinaplayers.com.au/bookings)  
or Just Funkin Music, River Street  
Ballina (0266 862440).

[www.lismoretheatrecompany.org.au](http://www.lismoretheatrecompany.org.au)  
[www.norpa.org.au](http://www.norpa.org.au)

# Achieving financial freedom

What does financial freedom mean to you? The ability to travel the world and build a dream home? Or to be able to enjoy a simple but active retirement, and support some good causes?

We all have different desires and goals in life, but most of us share the dream that one day we would like to achieve our particular version of 'financial freedom'. The challenge is that most of us don't really know what it takes to turn our goals, be they vague wishes or burning desires, into reality.

However, with just a little bit of forethought, some expert advice, and by acting on that advice, we are much more likely to reach that goal of financial freedom.

## Making the list

Your key ally in achieving financial freedom is your financial adviser, and amongst the most important things your adviser will need to know is what your goals are. So make a list and prioritise it. Which of your goals are essential, and which ones are you willing to compromise on?

## Reality check

Just as we have different goals, so do we have different financial resources. One of the first things your adviser will do is run a reality check. Given your income and expenditure, job outlook, health and family situation, are your goals realistic and achievable?

Your adviser will also check if key goals are missing. For example, life insurance can be an essential tool for protecting your family's future financial freedom, yet many people overlook it.

With the big picture now clear, your adviser can develop strategies that will bring that goal of financial freedom closer to fruition.

## Perfect timing

When's the perfect time to start your journey to financial freedom?

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Because the sooner you get started, the sooner your goals will be achieved.

So think about your goals and desires. Importantly, write them down. Then make an appointment to sit down with your financial adviser, and take those critical first steps towards achieving your financial freedom.

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



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## Hospital happenings

by Louise Imlay-Gillespie, Haematologist, Lismore Base Hospital

On 3 February 2020, the Clinical Year commenced! New interns arrived and we said farewell to many of our previous cohort. This year we have 12 new intern Rural Preferential Recruits (RPR) commencing at the Base to join the current 12 resident RPRs.

There will still be two rotating junior doctors from Prince of Wales as interns and residents (four in total) but our homegrown talent is certainly increasing. This year four of the interns had been students with us and liked us enough to return: generally our



Dr Louise Imlay-Gillespie

reputation as a centre is strong, attracting the other new RPRs. Lastly our retention from residency to PGY (postgraduate year) 3 was also very strong, with our managing to retain the majority of our previous RPRs compared to the state average of less than 20%

The year will see the second tower at Lismore Base Hospital opening, with many wards planned for decanting across in the next few months including the ICU. Exciting days ahead.

As always throughout the hospital there

are new recruitments and retirements occurring. Many of you may have come across Dr Jane Rigg's name in the past few months. She is our latest general physician who began in the middle of last year. Jane brings an intelligent, considered approach to her work having been trained in the Queensland system.

The end of 2019 also saw the closure of Dr John Burrell's career at Grafton where he had been working the past few years. John was a stalwart of both Lismore and Grafton Base Hospitals, and the thanks of us all go out to John who dedicated much of his medical career to our area. He will be sorely missed. The arrival of a new Director of O&G is imminent, which will hopefully see the service refreshed.

## Govt rejects pill testing, more injecting rooms, prisoner drug safety

by Robin Osborne

Following inquiries from GP Speak and sustained pressure from various quarters, including the Royal Australasian College of Physicians and the Ted Noffs Foundation, as well as a threat by the NSW Greens to have parliament force the document's release, the Berejiklian government has made public the special Commissioner's report into the drug 'Ice' (crystal methamphetamine) and other illicit substances.

The four-volume report follows the Commission's exhaustive hearings in Sydney and various regional settings, including Lismore, where drug experts, including ex-users, spoke of an epidemic of 'ice', the widespread misuse of other illicit drugs (and, notably, alcohol), and highlighted the lack of treatment and other support services in both the legal and health systems.

Despite a much-criticised delay in releasing the report the government was quick to respond to some of the key recommendations. It has rejected the advice to open more medically supervised injecting centres, run needle and syringe programs in prisons, allow consumer substance testing (a.k.a. pill testing) and



end the use of drug detection dogs.

Accepting such recommendations would entail what Commissioner Dan Howard SC called a "paradigm shift" required from health services, law enforcement and other agencies to drastically advance the battle against 'Ice' and other amphetamine-type stimulants.

This is neither the first official report on the vexing topic of drug misuse, nor indeed of 'Ice' specifically. From 2015-2018 the **Federal Parliament's Joint Committee on Law Enforcement conducted an inquiry** into crystal methamphetamine noting that, "... a person's drug use is a health issue and for this reason, Australian governments and law enforcement agencies cannot arrest their way out of it."

This sentiment was voiced countless times to Commissioner Howard's inquiry, including by police, and informs the

view of health practitioners and drug experts around the nation. However, the corollary to this is where things become controversial.

The Federal report noted a consideration (based on a visit) of Portugal's response to problematic drug use: decriminalisation: "Although decriminalisation exists in many different policy contexts in numerous countries (including Australia), evidence to the committee frequently identified Portugal's decriminalised drug policy as a model of best-practice."

The Berejiklian government's policy rigidity is far from this point and came as little surprise in a week when police were being criticised for illegally strip-searching minors suspected of harbouring drugs at music festivals.

Having moved swiftly on the recommendations the government did *not* support, Health Minister Brad Hazzard said it would consider the remaining 104 recommendations "in consultation with stakeholders" and prepare a final response before the end of the year.

These recommendations include the decriminalisation of the personal possession and use of 'Ice' and other illicit drugs.

# The GP guide to dementia care

by **Hilton Koppe**

Director of Education and Training,  
North Coast GP Training

## Background

Australia's ageing population - largely due, of course, to modern medicine keeping us alive longer - is resulting in an increase in the prevalence of dementia<sup>1</sup>, this increasing with age, from about 3.4% at 70-74 years to 20% at 85-89 years, and 40% at 95 years or over.

As the population ages, the number of people with dementia is estimated to rise from 200,000 (1% of current Australians) in 2005, to 730 000 (2.8% of the projected population) by 2050. Aboriginal and Torres Strait Islander people experience dementia at an earlier age, and at a rate 3 to 5 times higher than the general Australian population.<sup>2</sup>

Most people with dementia (84%) first report symptoms to their GP, but a delay between the appearance of dementia symptoms and a confirmed diagnosis is common, with one-half of those having early dementia not being diagnosed when presenting to primary care.<sup>3</sup>

While the morbidity rates are concerning the incidence of mortality is especially so, with dementia currently being the leading cause of death for Australian women and the second leading cause of death overall.<sup>5</sup>

Research published in BMJ Open has shown that attendance at GP lead dementia workshops has resulted in improvement in clinicians' knowledge about dementia and confidence to diagnose it in the general practice setting.<sup>6</sup>

Presently specialist services for the diagnosis and management of dementia are limited and are not meeting demand in some (notably non-metropolitan) regions.

Based on this demographic data, as well as service delivery gaps and research highlighting low levels of knowledge, confidence and training opportunities, there is an increasing need for GPs to receive training aimed at assisting them to better recognise, diagnose and manage dementia.

## Aetiology • Epidemiology • Pathophysiology • Pathogenesis

Dementia is a complex chronic condition, a clinical syndrome that can be caused by a number of underlying diseases in which there is progressive decline in general cognitive function beyond what might be expected from the normal ageing process.

It is not one specific disease and there is no one specific test to diagnose it. To add to the complexity, dementia affects people in many different ways. There is no "typical" presentation.

**Dementia affects an individual's thinking, behaviour and ability to perform everyday tasks. It is more than a memory problem. It is a progressive, global, life-limiting condition that involves generalised brain degeneration that affects people in different ways and has many different forms.**

Alzheimer's is the most common cause of dementia in developed countries, accounting for approximately 60% of dementia diagnoses.

Vascular dementia is the next most common cause, and there can be a mixed pattern as the risk factors for these illnesses overlap.

## The Three Stages of Dementia Framework

Dementia is a complex progressive chronic condition. The conceptual framework of The Three Stages of Dementia assists with the understanding of a likely trajectory of dementia. There are no fixed end points for each stage, but rather there is a gradual transition from Stage 1 through to Stage 3.

Utilising this stages framework also assists in developing appropriate goals of care. Because dementia is a progressive illness the goals of care need to change as the disease progresses. However patient "dignity" is an important core value to aim for at all stages of the condition.

In Stage 1 an individual is usually still at home and often quite independent. At this time our goal of care is to maintain **Dignity through independence**, focusing on enjoyment and quality of life. The aim is to keep people with dementia in Stage 1 for as

long as possible.

In Stage 2, the person with dementia will have increasing care needs. This is where GPs are most likely to become aware of problems in the home environment, as the families or carers present for help in managing their loved one. The goal of care in Stage 2 is **Dignity through safety**.

In Stage 3, the person with dementia will have diminishing quality of life, and will be requiring 24-hour care, most often in a residential aged care facility. The goal of care in Stage 3 is **Dignity through comfort**.

It is important to remember that everyone's journey with dementia will be different. These stages are offered as a guide for practitioners, people living with dementia and their families or carers.

## The Five Domains of Dementia Framework

Dementia is a complex condition involving a progressive global deterioration in brain functioning. To assist in better understanding how dementia, particularly Alzheimer's and Vascular Dementia, can affect a person, it is helpful to consider the conceptual framework of The Five Domains of Dementia.

1. **Cognition** – a gradual and progressive deterioration in memory and cognitive functioning.

2. **Functioning** – a gradual and progress deterioration in personal and social functioning as a result of cognitive decline.

3. **Psychiatric change** – may occur at any time during a dementia, either as a co-existing condition or as part of the dementia process. Early on in the dementia journey a person may become depressed or anxious in response to their cognitive or functional decline.

4. **Behaviour change** – behaviours that are out of character for the person with dementia. These may be in response to a lack of understanding of what is going on for them, e.g. if their care needs require them to be bathed by a stranger, or in response to pain or discomfort for someone who has lost the ability to communicate verbally.



Dr Hilton Koppe

5. **Physical decline** – as global brain deterioration progresses, physical functioning will be affected, e.g. mobility, swallowing, incontinence.

Combining the Domains and Stages Frameworks offers a model to explain the likely trajectory for a person living with dementia, especially in Alzheimer’s and Vascular dementia.

**Diagnosis • Investigations**

There is no specific brief diagnostic test currently available for dementia. Cognitive screening tests are screening tests, not diagnostic tests, and are used to identify people who may be at higher risk of dementia.

Diagnosing dementia in a timely fashion is important for the patient and their family or carers, as well as the GP. This allows for interventions which may slow the progress of the disease and for appropriate planning for the future.

The comprehensive diagnostic criteria for the various dementias can be found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-11). However, these criteria are lengthy and cumbersome to use in the general practice setting.

A deconstructed version of these criteria can help GPs to become more comfortable in making a diagnosis of dementia.

This deconstruction has broken down the complex criteria for Alzheimer’s dementia to **four inclusion criteria and three exclusion criteria**.

The **four Inclusion Criteria**, which are needed to make a new diagnosis of dementia, are

1. Gradual onset of memory problems
2. Progression of memory problems
3. Loss of function
4. Cortical dysfunction - dysphasia, agnosia or dyspraxia

The **three Exclusion Criteria**, which preclude making a definitive new diagnosis of dementia if present, are:

1. Delirium
2. Depression or other active psychiatric illness
3. Any other organic / reversible cause

It is important to note that the exclusion criteria may coexist with dementia, and even represent signs that a person is at increased risk of dementia. However, a person should not be given a new diagnosis of dementia until these exclusion criteria have been assessed, if present, and managed as best as possible. Once this has happened, the person should be reassessed looking for the presence of the inclusion criteria.

**Examination**

The role of examination in the assessment of a person with possible dementia is primarily to look for cardiovascular risk factors which could potentially be modified to slow the progression of a dementia, and to look for signs of cerebral ischaemia which may support a diagnosis of vascular dementia.

**Investigations**

The standard investigations done in the assessment of a person with a possible dementia is to look for possible organic causes of their symptoms.

**Cognitive screening tests**

Cognitive screening tests may support a diagnosis of dementia, but they are not diagnostic on their own. There are a number of validated screening tests available.

1. Standardised Mini-mental State Examination (MMSE) (template is standard in most medical clinical software, under Assessments).

2. GP Assessment of Cognition (GPCog)
3. Other cognitive screen tests for patients from culturally and linguistically diverse communities include:

a. The Urban Modified **Kimberley Indigenous Cognitive Assessment Tool (KICA)** for Aboriginal and Torres Strait Islander patients.

b. The Rowland Universal Dementia Assessment Scale (**RUDAS**)

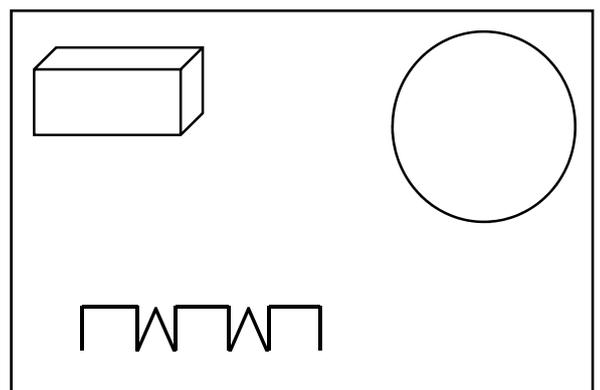
c. The Montreal Cognitive Assessment (**MoCA**) – available in a large variety of languages

4. The clock drawing test is a screening test of overall cognitive function, and relies on executive and visuospatial function.

Comprehensive neuropsychological testing is the gold standard for a diagnosis of dementia, but this can be expensive and encounter long waiting lists in many areas of Australia. These tests are best reserved for people with complex comorbidities or unusual presentations, including younger people.

Other screening tests can be utilised to diagnose or exclude any concomitant psychiatric condition. A Geriatric Depression Scale may be performed to look at a possible differential diagnosis of depression. If depression is thought to be the primary diagnosis, this should be treated and the person should be reassessed subsequently, looking for any signs of cognitive impairment which may be co-existing with the depression.

**References** for this article can be found on the **GPSpeak website**.



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## Meet your local pathology team



**Dr Sarah McGahan** MBBS FRCPA  
sarah\_mcgahan@snp.com.au  
(02) 6620 1203

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



**Dr Andrew Mayer** MBBS(Hons) FRCPA  
andrew\_mayer@snp.com.au  
(02) 6620 1204

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



**Dr Patrick van der Hoeven** MD FRCPC FRCPA  
patrick\_vanderhoeven@snp.com.au  
(02) 6620 1202

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

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# Concerns over long waits for public gastro care

Notable delays for public patients requiring endoscopy, especially colonoscopy, procedures are set to become even longer following a decision by consultant gastroenterologist Howard Hope to discontinue accepting referrals for patients needing upper GI endoscopy or colonoscopy at Lismore Base Hospital (LBH).

In a letter of 9 February 2020 to local referring doctors and other relevant parties, a clearly exasperated Dr Hope said the “prime reason is the excessive waiting times for public endoscopy at LBH, especially for colonoscopy.”

He stated that he and colleagues had been discussing the long waiting times with LBH management for many years.

In December 2019 he asked LBH managers to create a public Outpatient Clinic for gastroscopy and colonoscopy referrals. Referral to this open access Outpatient Clinic would help reduce the delay from GP referral to the appropriate procedure.

He added “The fundamental problem is that endoscopy waiting times (compared with surgical waiting times) are not a reportable performance indicator for hospital managers. In my opinion this is a serious failure of the NSW Department of Health policy.”

Explaining that the problem has been compounded by a colleague resigning from LBH, Dr Hope said LBH is currently negotiating with a clinician in the UK to commence as a Staff Specialist.

Meanwhile, risks to potentially seriously ill patients continue: “We have seen patients, appropriately referred by their GPs or Specialists, experience delayed diagnoses of cancer by up to 6 months. One of my colleagues is being sued for such a delayed diagnosis even though he triaged the patient as a category 1 (which is a recommendation to have the colonoscopy at LBH in 1 month).”

Dr Hope is keen to work with LBH Management to resolve this dangerous situation. In the interim he continues to



provide inpatient and oncology services to LBH. Consultations in his private rooms are similarly not affected.

He has encouraged GPs who feel strongly about this issue to lobby LBH Management in regard to commencing a public Outpatient service.

*Editor's note: We are advised that at the time of publication there is no outpatient clinic but negotiations are continuing.*



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# In Bali, seek the best and avoid the rest

by Robin Osborne

As the accompanying photos show, the Indonesian island of Bali is still an extraordinarily beautiful place, despite the endlessly negative stories about the behaviour of foreign tourists, including plenty of Australians, around coastal resort areas such as Kuta and Legian.

I'm more aware of this than most, having visited Bali in 1971 on the way back to my then-hometown of Hong Kong and being the only... read that again, the only, foreigner on Kuta beach to view the wondrous sinking of the afternoon sun into the sea. Now that spectacle must be shared with thousands of tourists gathered on beanbags outside bars blaring reggae, the Rolling Stones, whatever, over huge speakers, with collective cheering when the sun sets.

The Redgum song "I've been to Bali too", released in 1984, implied that one visit to Bali would be enough, that box was ticked, but for me too much Bali has never been enough, assuming you stick to the best places, Ubud in the hills being prime amongst them, and avoid the rest.

Speaking Indonesian, the lingua franca of our neighbouring country of 270 million people, mostly outside Bali, helps of course. All Balinese speak it, along with the various cast-influenced levels of their own language.

These days there is something apart from Bali's beauty on the menu, quite literally as some top restaurateurs are hanging out the fine-dining shingle for those wishing to go beyond fast food, nasi goreng (fried rice) and lots of Bintang beer.

Their numbers include Janet de Neefe, married to a Balinese and founder of the Ubud Writers Festival, who runs several restaurants and has published an admirable cook book, Bali: The food of my island home. Another is Will Meyrick whose properties, specialising in Indonesian-fusion food, include Ubud's Hujan Locale. His passion is helping train



Tegalalang rice terraces



Bali building bamboo

Balinese in the kind of food preparation and service sought by discerning visitors.

Another pivot is the increasing popularity of Bali as a "wellness" destination, in other words less Bintang and cheap cocktails at the swim-up bar and more downward-dogs

at the multiplying yoga schools and health retreats. In a recent feature on how "yoga is replacing parties for Aussies visiting island paradise" The Weekend Australian (11-12 Jan 2020) said the Yoga Barn in Ubud attracts more than 400 people a day to classes, and employs 170 staff.

Although perhaps over-hyped, this latest addition to the tourist mix opens up a new market at a time when the Balinese economy is continuing to struggle, despite the constant stream of international flights arriving at Denpasar's massively upgraded terminal each day. Arrivals could not be more different to those who came here nearly fifty years ago when I first set foot in a place that seemed to exist more in legend than reality... or in a stage show, South Pacific, with a featured song "Bali Hai" that referred to Hawaii.

But despite all, and the shameless alienation of farm land for golf courses and resorts, the real Bali is still there, not many hours flying time north, and the Balinese are genuinely delighted to welcome us, to try to explain their complex culture if we show interest, and to thank us for visiting.

I've been to Bali too, and hope to be doing so for many years to come.

# John Flynn Placement Program returns to Clarence Valley

The Clarence Valley Regional Training Hub has partnered with the Clarence Health Service and the NSW Rural Doctors Network to support the return of John Flynn Placement Program (JFPP) students to the Clarence Valley region. Students from the University of Wollongong, University of Sydney, University of Queensland, University of New England and University of New South Wales had the opportunity to undertake clinical placements at Grafton Base Hospital (GBH) from November 2019 through to January 2020.

These students were very pleased to have had the chance to experience clinical training in the emergency department of GBH under the guidance of JFPP mentor Dr Alastair McInnes. GBH has diverse presentations that enable the students to observe the team managing everything from run of the mill ailments to retrievals.

Students were also able to access education through the simulation suite, which sees a diverse mix of clinical and multidisciplinary educational offerings. The JFPP students actively participated in the Christmas-themed simulation session which had Santa present with leg burns and antlers protruding from his torso. These students also attended grand rounds presentations at the GBH.

The Grafton JFPP program enables exposure to all aspects of rural health, an example being the Clarence Health Service High Risk Podiatry Clinic at Maclean Community Health. This team takes a multidisciplinary focussed, patient-centred approach, with coordinated care at the fore front of their service delivery. This is an ideal opportunity for students to have first-hand experience in this approach to patient care.

Some of the students were able to follow patients from emergency triage through to the operating theatre and then next day found themselves doing activities like ward rounds with the paediatric team and observing baby health checks in the maternity unit. The weekends were left free for them to enjoy living (albeit briefly) in Grafton and exploring the region, visiting Yamba markets, scuba diving, having pizza nights and visiting farms.

Joanne Chad  
Clarence Valley Regional Training Hub  
University of Wollongong



JFPP students Ruben and Clare with Dr Alastair McInnes



Evie and Sam Kayaking in Yamba

One JFPP medical student summed it up by saying:

“Around every corner at Grafton Base Hospital was a friendly, smiling face more than willing to give you a part of their day to say hello, point you in the right direction, help out or teach you something new. The experience I had at GBH was, for lack of a better word, incredible. The teaching and exposure to rural medicine is the best to date that I’ve had, by some of the most friendly staff I’ve ever been lucky enough to get to spend some time alongside. Genuinely feeling like part of the team was something quite different to some of the bigger hospitals where it is all too easy to get lost in the everyday busyness and sometimes seemingly chaotic nature of a tertiary centre. I feel very privileged as part of the John Flynn Placement Program to be able to have 2 weeks every year in such a great environment. I can’t wait to come back again.”

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JFPP student Gareth with nursing students



JFPP students Evie and Samantha

cont from P32

Another JFPP medical student said:

“Thank you so much for organising everything for us! We had an absolutely fantastic time - everyone was so lovely and our JFPP mentor, Dr Alastair McInnes, was amazing! We learned a lot and it was great just to get a feel of the hospital and how it all works!”



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## Australians like their GPs, worry about costs of meds and dentists

Patient satisfaction with GPs continues to rate highly, with 94 per cent of Australian adults thinking their doctor shows respect for what they say, and 91 per cent saying their GP always or often spends enough time with them.

Evidently the primary care being provided is serving the purpose, with 86 per cent of adults reporting their health to be excellent, very good or good. Some 81 per cent of all adults had seen a GP in the past year, according to the 2017-2018 patient experience figures released by the Australian Institute of Health & Welfare.

Less pleasing is the high number of people who say high costs mean they avoid or delay filling a prescription and need to put off visiting the dentist.



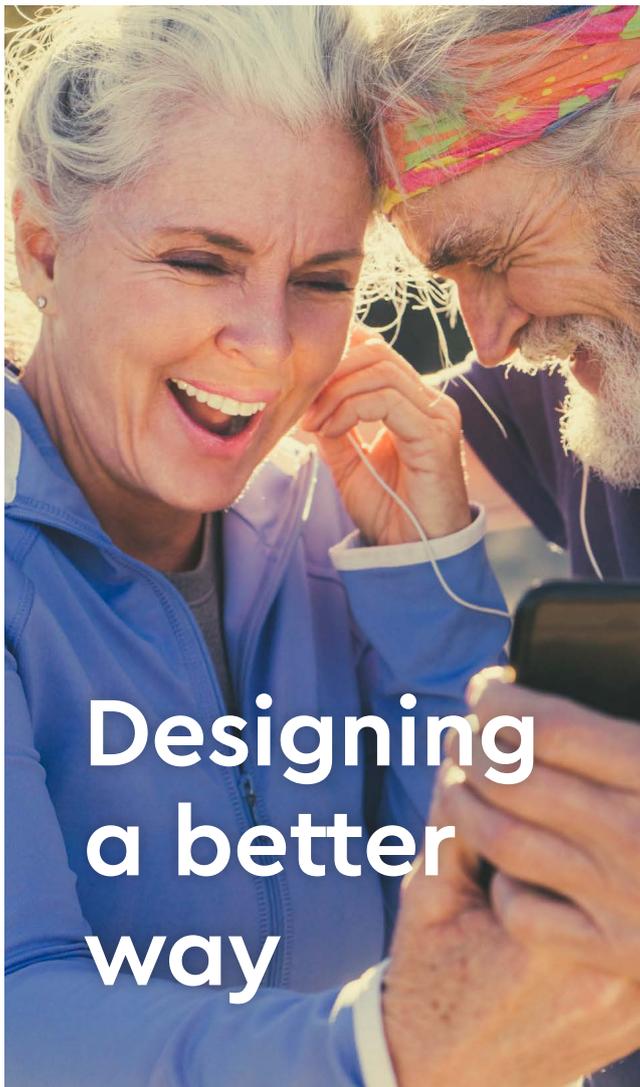
In some parts of metro and regional areas the decision to delay filling a prescription has risen by up to 50 per cent over the past three years, the AIHW found. This is despite PBS subsidies for most prescribed medications.

Health analysts say that delaying professionally prescribed treatment – Australian doctors write around 120

million scripts per year – is likely to have significant implications for a person’s health as well as an impact on the health system at large as their condition may worsen and necessitate higher level treatment, including hospital care.

The costs of private dental care, along with the lack of Medicare support and long public dental waits, continues to have a major impact on both oral health and on associated conditions, for instance cardiac disease.

Nationally, almost one-in-five people needing dental care were found to have postponed or avoided the dentist in the past 12 months due to cost.



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**Professor David Christie  
Radiation Oncologist**

Professor Christie visits Byron Bay clinic once every third Friday and has extensive experience in treating all major cancer types including prostate, 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:**

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**Radiation oncology  
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**Tel: 07 5507 3600**

GenesisCare  
Premion Place  
39 White Street  
Southport Qld 4215  
**Tel: 07 5552 1400**

For further information about the Byron Bay clinic service please contact our Tugun centre:

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oncology.tugun  
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# Book Review

by ROBIN OSBORNE

## Nine Pints

By Rose George  
Portobello Books 372pp

In early February a Thai soldier stole guns from a military barracks and went on a shooting rampage - which he livestreamed - killing more than twenty shoppers and wounding many others. According to an early report, "Authorities have asked for blood donations and put hospitals on alert."

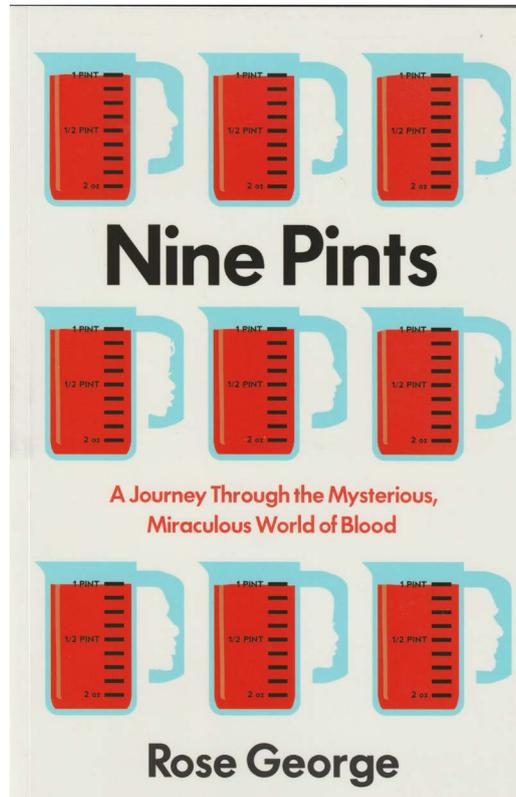
As with the development of many drugs and medical procedures, the transfusing of blood into trauma victims has its origins in wartime. The author of this unexpectedly gripping book says "the modern era of transfusion" began on 16 October 1914 when a seriously wounded soldier was brought to a field hospital in Biarritz, bleeding out.

In the same ward lay a "small, brave Breton", recovering from his injuries, who was asked if were willing to share some blood with a comrade.

"It is a sensible request: transfusion required proximity, because you needed to do it quickly to beat the blood clotting," Ms George explains.

Working without pain relief, doctors cut into the dying soldier's vein, connected him to the donor by a silver tube and drew blood for two hours. The results were spectacular. The recipient was revived, and leant over and kissed the donor on both cheeks, "because he was French," as the author quips, "and because he was alive."

In 1915 indirect transfusion was pioneered by a Canadian surgeon using a technique he had learned in civilian life. This involved withdrawing blood, transporting it in a syringe, and then transfusing. By the end of WW1 casualty stations on the Western front were transfusing to around fifty wounded personnel daily; by WW2 field transfusion



unit trucks carried fridges holding 1100 pints of fresh whole blood.

"At the battle of El Alamein," writes this award-winning journalist and author, "one in ten men received blood, three bottles each."

In "Code Red", a later, harrowing chapter on the transfusion theme, we read of the role played by blood and blood products in treating the kind of patients traumatised by the likes of the rogue Thai shooter. Ms George describes the case of a cyclist hit by a London bus, a woman who "probably lived with the belief that all inhabitants of a major city must hold to themselves like treasure: that nothing bad will happen today. Nothing will hit, or crush, or crash into, or stab, or shoot, or damage them."

Yet this unfortunate, like so many others, not least in terror-prone London, was smashed to Smithereens, "from an old Irish word meaning 'small pieces'".

As we follow the cyclist to the ED and

the highest level of emergency care available, we are told that "Bleeding" according to Karim Brohi, a trauma and vascular surgeon at Royal London, "is the biggest disease you have never heard of", accounting for 10 per cent of world deaths, one-third more than the combined fatalities from malaria, TB and HIV/AIDS.

Each of the in-between chapters focuses on a particular topic and a simple list illustrates the diversity, the link of course being blood: leeches, once traded like, and indeed for, slaves; Dame Janet Vaughan, an academic, and Percy Oliver, a public servant, pioneers of the British voluntary blood donation scheme; blood borne diseases, notably HIV; haemophilia; religions that eschew blood transfusion; and two harrowing chapters, largely but not exclusively set in developing countries, on menstrual bleeding and the long struggle to provide accessible sanitary pads and related items to all females without discrimination.

In the first footnote to the first chapter, "My Pint", the author, a committed blood donor, notes that "the general rule is that blood volume makes up 8 per cent of a person's body weight... I weigh 65 kg... [so] 5.2kg... Converting kilograms to pints (though it's mass to liquid) gets 9.15 pints."

That's 5.11 litres (assuming the nine pints are the Imperial measure), a little more than ten times the average blood donation in the UK.

Ms George has written about a range of subjects high on the social agenda, including refugees, waste management and how shipping, the "invisible Industry" brings us much of what we consume [https://www.ted.com/talks/rose\\_george\\_inside\\_the\\_secret\\_shipping\\_industry/discussion](https://www.ted.com/talks/rose_george_inside_the_secret_shipping_industry/discussion)

This latest focus, "A Journey Through the Mysterious, Miraculous World of Blood", is quite a trip.



**Item 291  
outpatient  
mental health  
assessments**

## **Bulk billed private mental health assessments available now** for patients impacted by the recent bushfires

Due to the devastation and long lasting impact caused by the recent bushfires in Australia, **Dr Matt McDornan** and **Dr James Whan** at **Healthe Mind Bangalow** would like to offer support to GPs and their patients with issues arising from these fires, by providing bulk billed MBS Item 291 and 293 appointments.



**Dr Matt McDornan**

For further information and to arrange an appointment please contact Healthe Mind Bangalow by phoning 02 6687 2331 or faxing your referral to 02 6687 2336.



**Dr James Whan**

Item 291 appointments offer a one-off outpatient mental health assessment and Item 293 appointments offer a review of this assessment.

For patients requiring private inpatient treatment or day patient options please contact Currumbin Clinic's Admissions and Assessment team on 1800 119 118.

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