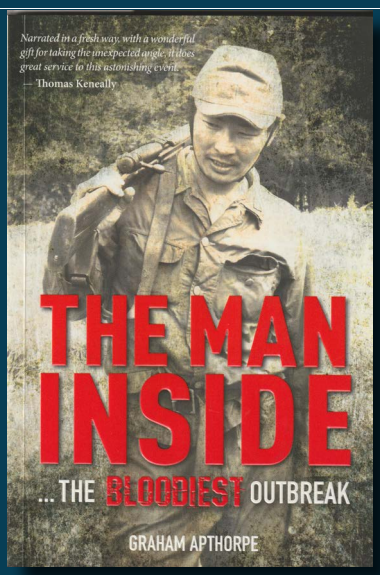
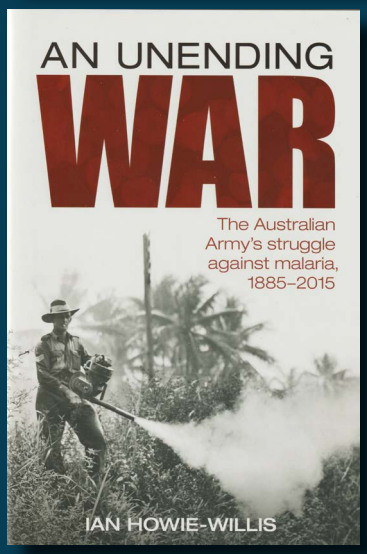
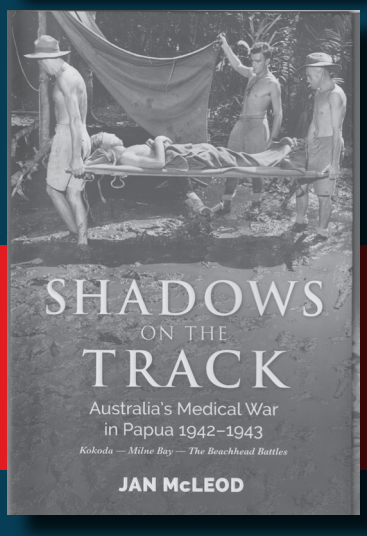
NorDocs

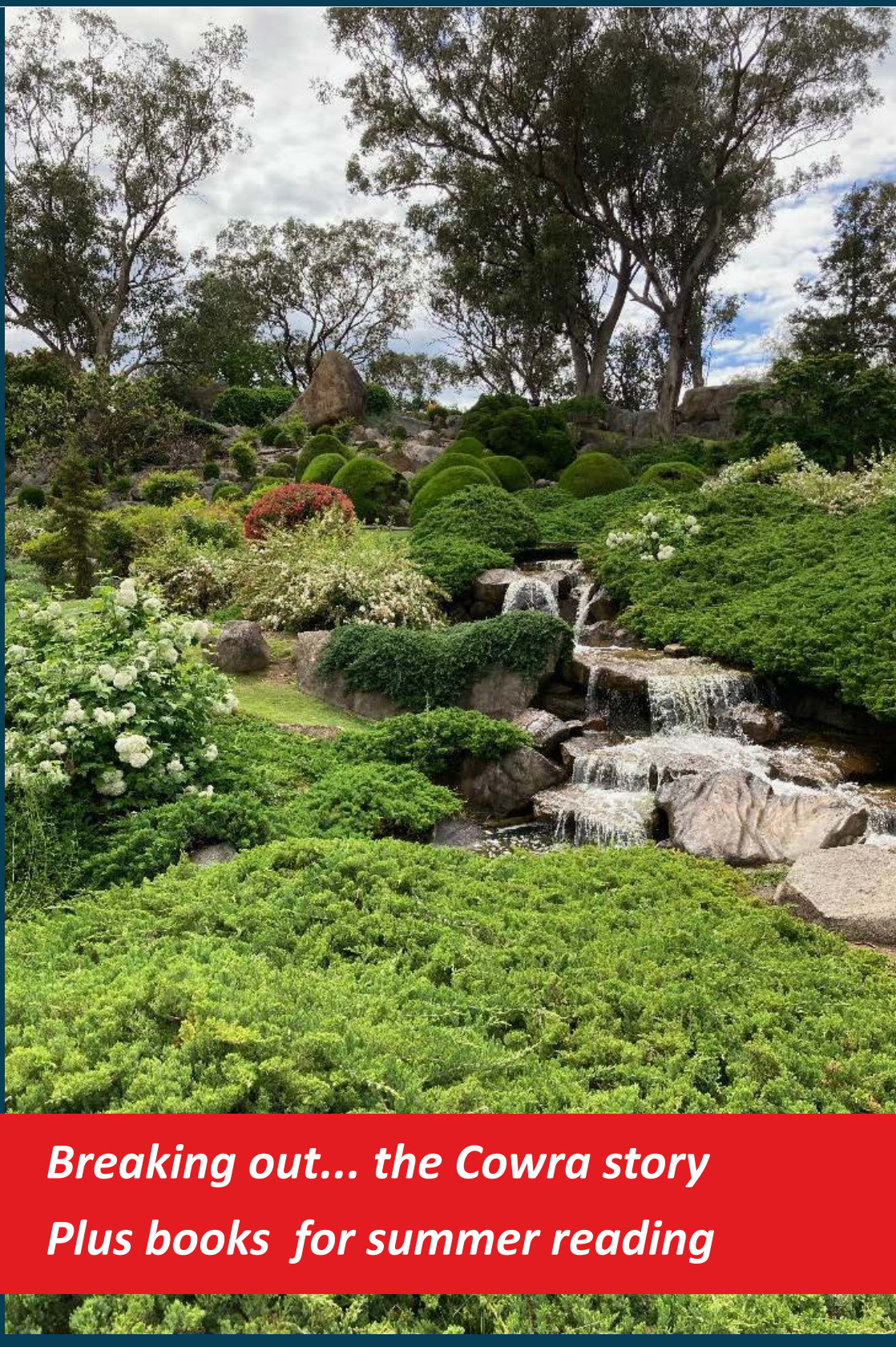
The quarterly magazine of the Northern Rivers Doctors Network

Summer 2020 - 2021









Breaking out... the Cowra story

Plus books for summer reading

ⓔ info@nordocs.org.au

ⓦ nordocs.org.au

NorDocs

The quarterly magazine of the Northern River Doctors Network

Published by:
Northern Rivers Medical Network
info@nordocs.org.au
www.nordocs.org.au

IN THIS ISSUE

NorDocs on the web: www.nordocs.org.au

SEARCH - NorDocs is available in pdf and Issuu format from our website. **Article references are available via the online hot links.**

SUBSCRIBE - Get the latest from NorDocs by subscribing to the newsletter that comes out once or twice each month. Add your email address to the form in the right sidebar.

WRITE - Unless otherwise stated all articles in NorDocs can be reshared under the Creative Commons Attribution-ShareAlike 3.0 Australia license.

NorDocs welcomes contributions from members and the general public.

TWEET - Follow **@nordocs_nsw**

Overseas and interstate trips have been on hold because of COVID-19 restrictions, meaning many holiday-makers have been hitting the road within NSW. They include our editor who did a swing through the western district of the state, including the town of Cowra, the site of a WW2 prisoner-of-war camp in 1944.

The camp was the scene of a catastrophic escape attempt by Japanese army and naval personnel, 231 of whom were killed, along with four Australian army guards. This was the so-called "Cowra Breakout".

In 1979 the memorial garden pictured on our cover was opened. Situated close to the remains of the former prison and Japanese war cemetery it is the largest Japanese garden in the southern hemisphere, and a must-see for road-trippers 'breaking out' to tour regional NSW.

Read the story and see more photos on page 39. Photo: Robin Osborne

Summer 2020 -2021, Editorial

David Guest
Clinical Editor

"All in all you're just another brick in the wall."

Pink Floyd, 1979

by David Guest

For many Australians the end of 2020 will bring a sigh of relief … of having made it. As the reality of the COVID-19 epidemic became clear in Autumn anxiety levels rose in the Australian community.

There was a great fear of the unknown and the fear of possible serious infection and death. Nations embarked upon real time experiments on the best ways to control the pandemic where, unfortunately, there were no control groups.

There was uncertainty about how the disease was spread and what measures were effective in controlling it. There was soon recognition that the disease was far more lethal in the elderly than the young. Some countries decided to follow a herd immunity approach to the pandemic. Such an approach was considered cynical and was not widely adopted. The elderly vote.

Isolation and contact tracing emerged as the most effective methods of managing the disease. For once, being remote islands at the other end of the world was an advantage. New Zealand led the way and after a few false starts Australia followed.

The effectiveness of contact tracing in Australia is a tribute to Australian public health physicians. Their success depended on traditional "shoe leather" measures and high tech approaches like the government's COVID contact smart phone app played little role.

The "check in" apps at venues however were a valuable resource for the contact tracers. If nothing else their use pushed forward the uptake of smartphone technologies amongst the elderly and with the aid of restaurant and hotel staff most could still get a feed.

Similarly with the help of friends and neighbours many older Australians mastered the art of Zoom and were able to keep in contact with their children and grandchildren. Zoom drinks and dinner parties were OK, not as good as the real thing, but at least there was less mess at the end of the night.

COVID enabled the more rapid uptake of "e-technologies" as we report on page 13. Tele-consultations enabled the continued delivery of medical services, again not as good as the real thing, but better than nothing.

Medical services suffered only minor downturns compared to the hospitality, tourism and the entertainment sectors, while others, that focussed on home and vehicle maintenance and improvement, boomed.

Despite the generosity of the government expenditure in COVID related medical care, in other areas of medicine they continued to tighten.

General practitioners and the profession generally are having their autonomy in clinical practice increasingly restricted. What's in and what's out is decided on a population basis with a significant input from the health economists. The views of the profession are neither sought nor considered.

The result is an increasingly common view that Medicare is becoming irrelevant to large parts of one's clinical practice.

The year started off with a crackdown on "dual billing", the practice of charging a mental health consultation along with a standard consultation for other physical problems. Dual or multiple clinical problems are common amongst those with mental health issues. Transport problems, particularly in the bush, are also common in this group making the Department's suggestion of dealing with separate issues on separate occasions impractical.

The Department targeted a small number of GPs with a letter counselling them on their practice styles. Receiving such letters is never fun and the bitterness one feels often results in a change in practice or even **giving up completely** as NorDocs member, Susan Tyler-Freer can attest. **Healthcare by algorithm** aims to get rid of the deviants.

Further whole of health changes followed quickly. Proton pump inhibitors (PPIs) restrictions were applied due to observational studies noting a possible association of these medications with various potential diseases (kidney disease, dementia, hypomagnesaemia, pneumonia, osteoporotic fracture, etc).

While the **recommendation to use smaller doses** for shorter periods of time had been around for a few years there was little change in prescribing until the PBS stepped up. Basing the change on less rigorous scientific principles (observational studies only) can be argued but for the economists the recommended change was a slam dunk.

As with PPIs the regulations over inhaler medication has changed continually over the last few years. Over the counter (OTC) bronchodilators became available under pharmacist review. Combined bronchodilators and steroids inhalers were in, then out and now partially in again. Inhaled steroids for COPD was restricted to severe cases reflecting new information that had become available. There were sound scientific principles behind most of the decisions but the frequency of the changes made it seem more like the fashion industry was in charge.

Fear of the American opioid epidemic taking hold in Australia prompted limitations in the prescribing of narcotics. OTC narcotics in low dose disappeared first, followed by limitations on the quantities and repeats that could be dispensed. While this was mostly welcomed by GPs our therapeutic armamentarium became very restricted. An increasingly aging population with shoulder and back pain is frustrated by our recommendations to limit their activities, do more supervised exercise and lose weight. There are no magical cures either from our drugs or from a trip to the pain clinic.

continued on P4

Summer 2020- 2021, Editorial

continued from P3

Sleep apnoea testing was next. Once again age, obesity and alcohol have combined to create an epidemic of obstructive sleep apnoea. Restricting access to those meeting clinical criteria is wise but where clear cut cases do not meet the proscribed threshold the recommendation for sleep physician review is impractical in rural settings with current waiting lists over six months.

The latest action by the Department has been a cut to MBS rebates for ECG interpretation by GPs. (Restrictions on cardiologists doing frequent echocardiograms were also applied.) The Department explained this was one of the recommendations from the Robinson review into the MBS schedule and that both Professor Robinson and Professor Harper, Chair of the Cardiac Services Clinical Committee (CSCC) of the Medicare Benefits Schedule (MBS) Review Taskforce, had signed off on the recommendation.

It sounded like the recommendations had come straight out of **Catch 22**. You didn't need to do the interpretation if the ECG was normal but you could not make that decision unless you did the interpretation of the ECG. Listening to the Department explain the rationale for their determination reminds one of a **Trumpian Communications Director press conference**. Perhaps the profession will come up with "alternative ECGs" just as it did previously with GP steroid joint injections.

Primary health networks were set up by the current Coalition government in 2016 to coordinate primary care at the local level. Unlike their predecessors the Divisions of General Practice they are not a GP focussed organisation and their main function is to commission primary care health services at the local level.

The PHNs have evolved over the four years since their inception and on page7 I put forward one view of their current status.

The focus of PHNs on the social determinants of health correctly centres on issues of poverty, housing, education, crime and institutional racism. It is not terribly concerned with the quality of medicine practised in the area and the decreased emphasis on general practice has come as a surprise and disappointment to many GPs.

The closure of the North Coast Primary Health Network's quarterly magazine, Healthspeak, was seen as removing one of the communication channels from the PHN to local GPs. It was replaced by weekly updates via e-newsletter of the events, courses and programs of the NCPHN and its partners. This is arguably a more cost efficient way to disseminate information in this day and age, and the NCPHN is leading better value communication for others to emulate.

In May the NCPHN decided to run their education program internally and no longer felt there was value in commissioning the task to the external provider, North Coast GP Training. However, most GPs have been disappointed with the first six months of the NCPHN program and many have wondered if the NCPHN's skills lay more in the area of commissioning rather than education provision.

The NCPHN has worked with Sydney based Sax Institute System in elaborating a Dynamic model for Mental Health/AOD on the North Coast. Modelling interventions is a tool to help target funding to those areas and programs that will have the most significant impact.

The Sax model showed **a detrimental effect of getting GPs involved in mental health care**. This is an important finding if true but that is far from established. Tweak the model and a completely different set of results and recommendations will result.

Modelling is a fascinating topic but models are more often wrong than right when it comes to predicting human activities. Analysing human economic behaviour is difficult and millions of dollars have been spent in predicting where the stock market will go and have failed. Getting predictions correct in health interventions is even more problematic. Most concerning is the fact that the model is neither open nor peer reviewed.

Economics is often referred to as **the dismal science** and their models are of limited use. The satirists portrayal of the modellers, "You've got questions. We have assumptions." is depressingly accurate.

The Board of the North Coast Primary Health Network sets policy and direction for the organisation. Chairman of the Board, Dr Tim Francis, a GP / anaesthetist from Nambucca is retiring after nine years on the Board. (Appointments are limited to three terms, each of three years.) Scott Monaghan from the Bulgarr Ngaru Medical Aboriginal Corporation in Grafton is also leaving having completed this maximum period of time on the Board.

Also leaving is Naree Hancock. Naree has been a long time administrator in rural health, education and business. Naree has also been on the Board of North Coast GP Training from 2013 to 2019.

Another Board member of both NCGPT and NCPHN, Dr Chris Jambor, had resigned earlier in the year when North Coast GP training was negotiating for the continuation of the education contract.

This leaves up to four positions for Board membership to be filled. Two of these will be decided at the 2020 AGM on 8 December 2020 and the candidates are of very high quality with national and international corporate experience in telecommunications, the law, human rights and human relations.

The other two positions can be filled by the Board by appointment. As defined in the PHN's Constitution, it is essential that the Board's "directors having appropriate competencies, skills and experience in light of the Skills Matrix (if any), and in particular having expertise in areas including knowledge of health care provision and its relationship to local communities, business management and accounting and legal issues".

The NorDocs Annual General Meeting is on December 17 at the Goonellabah Medical Centre. Members may participate in person or by Zoom.

I commend Chairman Nathan Kesteven's report to you (page 5) and the NorDocs Board welcomes nominees for Board Membership and input and guidance from members on where our focus should be for the future as we continue to explore our place in these interesting times.

NorDocs Chair Report 2020

by Nathan Kesteven

This year has been unforgettable, to paraphrase Nat King Cole (though not necessarily for the same reasons!). However, 2020 has presented NorDocs with some new opportunities, along with new challenges. We are pleased that membership has expanded from GPs to include all doctors working in the Northern Rivers.

We are also pleased that our Board membership has increased and we welcome new Lismore Base Hospital staff surgeon, Trafford Fehlberg, and Mullumbimby GP, Helen Lloyd, to the Board.

The aim of NorDocs is to represent all medical practitioners within our region and to advocate on any issue that either impacts us or which we feel needs addressing.

We try to be an open and welcoming forum for members to discuss any matters that they wish, as well as being a forum for further education of our members.

This year we welcome our new administrative officer, Linda Ward, who has a background in nursing and practice management. Linda currently runs her own consulting business on medical practice administration, and in the past has worked for the Improvement Foundation and the North Coast Primary Health Network.

I would like to thank both Linda and David Guest for all their hard work in establishing the monthly NorDocs Webinars, which we plan to continue next year. The topics pencilled in so far are ENT, Orthopaedics, Eating Disorders, Palliative Care, Gynaecology and Surgery, and we welcome suggestions for more topics and for local speakers.

Breaking down the silos in healthcare is an important part of improving patient care. Recently myself and GP members of the organisation have joined with the Northern NSW Local Health District working group on improving wound management.

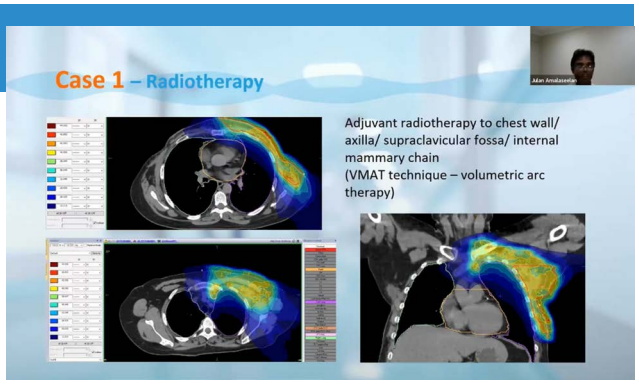
By working with local podiatrists and community nurses across the whole footprint of the LHD we aim to improve management of this time consuming, expensive and often chronic problem.

GP and private podiatry participation has been aided through financial support from the North Coast Primary Health Network.

The group hopes to release its recommendations in the second half of 2021. We are keen to hear from any of our members about any issues or ideas that you may have for better healthcare on the North Coast. We can be contacted on **info@nordocs.org.au** or email Linda Ward directly on **admin@nordocs.org.au**.

We wish you all a safe and happy holiday season, and a well earned break.

NorDocs webinars



NorDocs like the rest of the medical profession embraced webinars this year for its education program. When it became clear in early Autumn that the annual NorDocs Unconference held each June would not be possible this year it was agreed to trial the webinar format.

The philosophy behind our education program has always been that there is great value in local doctors speaking with their colleagues about the latest developments in medicine and how these might best be applied in our region.

Historically new approaches in medical practice take ten years until they are widely adopted. While there are few major breakthroughs, multiple small innovations bring about significant changes in day to day practice. It has been argued that the half life of knowledge in medical practice is ten years. While this timeframe has been questioned, all agree that it is quickening.

In August Drs Dom Simring and Jowita Kozlowska presented an update on carotid artery disease management. The session was facilitated by Cape Institute's Medical Director, Dr Peter Silberberg. Cape has a long history in GP education and believes the traditional, case presentation style is the best for that target audience.

The format aims to limit the webinars to an hour with the presentation of two or three cases that each highlight some of the identified key learning points. Each case is followed by a short question and answer session. This format, focussing on the key points while allowing the audience to raise other issues and questions makes the meetings both entertaining and informative.

Confining the webinars to an hour, although admittedly they do tend to drift over that with the permission of the facilitator, is not too taxing for most practitioners at the end of a busy day. For those who are interested in the topic but cannot make the night, the meetings are recorded. The **2020 recordings** can be found on the **NorDocs webinar website** and are freely available to NorDocs members.

The other meetings held this year were "A case of rashes and a rash of cases", an update on psoriasis from the doctors at North Coast Dermatology, "Breast cancer management and MDT" with Rob Simon, Amy Scott and Julan Amalaseelan, and "Breathe Easier" with all three Lismore respiratory physicians, and the Pulmonary Rehab team of Lyn Menchin and Rocco Mico. The take home message from these three meetings is that biologics are big.

Feedback from users suggests that a meeting on a Tuesday or Wednesday night at 7.30 pm is the best time and NorDocs will hold a meeting each month from February to June 2021 in the second week of the month at that time. The topics requested by members to date are in ENT, Orthopaedics, Eating Disorders, Palliative Care, Gynaecology and Surgery.

Running the meetings is quite expensive and NorDocs thanks the sponsorship provided to date from Abbott Vascular, St Vincent's Hospital and Janssen Immunology for their generous support.

If there is sufficient interest NorDocs would like to expand the program outside the Richmond Valley to the rest of our community in The Tweed and Grafton. Members interested in assisting us in this regard should contact nordocs-webinars@lists.nordocs.org.au .

5 ways to benefit from record low interest rates

Interest rates have never been lower, and it's possible they might fall even further. This creates opportunities for house-holders and businesses, so how can you best take advantage of low interest rates?

1. Pay off your debt more quickly

By maintaining constant repayments as interest rates fall, you'll reduce the time it takes to pay off your loan. That's because interest will make up less of each repayment, with more going to reduce the outstanding capital. And the great thing is that to take advantage of this strategy you don't need to do anything. Lenders usually maintain repayments after each drop in interest rates unless you instruct them otherwise.

2. Refinance your home loan

Lenders vary in the extent to which they pass on cuts in official interest rates. So, if you want to reduce your loan repay-ments it might be worth shopping around to see if you can find a better deal from other lenders. Just make sure that, if switching lenders, you take all fees into account to be certain you really are saving money.

If you are restructuring your borrowing, another thing to consider is fixing the interest rate on all or part of your loan. This can provide protection from the impact of rising interest rates in the future, though it may mean you benefit less from any further cuts in rates. However, with interest rates already very low, there simply isn't the room for rates to fall much further.

3. Buy a first home – or upgrade

Low interest rates create opportunities for first homebuyers to get a toehold in the property market, and for existing homeowners to upgrade to a bigger home or better location. While lower interest rates can be a bit of a two-edged sword, as they tend to drive up property prices, most people are happier borrowing in a low rate environment rather than when rates are high.

4. Borrow to invest

While Australians love to invest in property, borrowing to invest in shares is also a viable wealth creation strategy. Often referred to as gearing, the key to successfully investing borrowed funds is that the total returns must exceed the total costs. As the most significant cost is usually the interest on the loan, low rates make this strategy more attractive.

Take care, however. Gearing can magnify investment returns, but it can also increase your losses. It's therefore important that you fully understand investment risk and how to minimise it.

5. Expand your business

The whole point of a reduction in interest rates is to stimulate the economy, and that includes encouraging business owners to invest in their enterprises. Low interest rates make it cheaper to borrow to buy equipment to increase produc-tivity, to take on more staff, or buy out a competitor and generally expand the business.

Take advice

Some of these strategies are simple 'no-brainers'. Others involve significant levels of risk. To take a closer look at how you can make the most of low interest rates, talk to your financial adviser.

Whither the PHN?

by David Guest

Australia's Primary Health Networks (PHNs) were originally envisaged as local organisations that knew their local area (a large one) and its needs and could tailor their programs to the population's individual circumstances, aligning this with clinical capability. They arose following **a review of their predecessors, the misnamed Medicare Locals**, in the view of Prof John Horvath who reported on their performance in May 2014.

Sten, CC BY-SA 3.0, via Wikimedia Commons

The theory was that by devolving a lot of decision making from Canberra to 31 geographic areas, each having just under a million people, the Federal Government could be more efficient in getting value for the nation's health dollar. Many GPs welcomed this approach and looked forward to having a close working relationship with their PHNs to improve the planning and delivery of primary care.

One criticism of the Medicare Locals was that, on occasions, they were direct providers of services and thus in competition with other similar providers in their areas. The conflict caused by this direct competition was deemed unfair by the Coalition government, which traditionally prefers a market-driven approach to funding government services.

PHNs were thus designed to only be commissioners of services and provide no clinical services directly themselves.

PHNs are lean organisations that focus on local issues and how to address them through commissioning local services. They concentrate on the government's priority areas of mental health, ATSI health, population health, health workforce, digital health and aged care. There is only limited funding for other activities that are designated flexible, and innovation funding.

PHNs **eat their own dog food**. The Federal government contract to run a local PHN is put out to competitive tender. In our area the recently rebranded Healthy North Coast was the successful tenderer. HNC is set up as a company limited by guarantee and is registered as a charity. This is a common approach for most PHNs.

The North Coast PHN is structured such that its members are local organisations and not individuals. Initially these member organisations had a strong focus on, and relationship with, general practice. However the number and influence of GP-led organisations within the membership has diminished in recent years.

The primary responsibility of companies' Boards of Directors is to the continuing viability of their organisations. To maintain financial viability they have to protect their income base.

PHNs derive the vast majority of their income from Federal government grants. As such the PHNs are 'captives' to the Department of Health and essentially fit the model of being **quangos**.

The PHNs obtain local input by undertaking their own assessments as well as from their Consumer and Clinical Councils. Of course, getting consumer input is historically a difficult task in health and education and is often just tokenistic.

Clinical Councils were warmly embraced by GPs initially and many looked forward to a better working relationship with allied health and the secondary health sector. However, as time has passed GPs have found that many of the problems identified by Clinical Councils cannot be addressed by their local PHN because the issues raised were deemed out of scope or exceeded the PHN's discretionary budget, or simply required more manpower than the PHN had available.

Company Boards are ultimately responsible for the direction of the company and are the body to which the Executive answers.

Divisions of General Practice were the first government funded local organisations whose focus was on local primary care. Their Boards were composed solely of GPs. However, after a decade it was recognised that companies needed Board members with skills outside of medical practice in areas such as finance, management and governance. Directors with these skills were appointed directly by the Board and not elected by the membership.

These arrangements have been further refined over the last ten years and an increasing number of Australians from business and the public sector are now enjoying a second career as Board members of charities such as PHNs as well as other publicly traded companies.

The burden on the membership in reviewing an increasingly large number of applicants for Board positions have been addressed by some PHNs through the mechanism of Nomination Committees. Unsuitable candidates are weeded out and the membership organisations have only a small list of applicants to consider for election as Board members at the Annual General Meeting.

The downside of this arrangement is that general practitioners who previously would have been a GP organisation's nominee do not get past the Nominations Committee.

In essence the Nominations Committee has become the de facto membership and this has further weakened the influence of general practice in the directions of their PHNs. Some commentators have argued that these arrangements have resulted in a flawed governance structure for Primary Health Networks.

The frustration caused by these various factors has now come to fruition and many GPs previously on PHN Boards and Clinical Councils have walked away. GPs

continued on P9

A lifetime in psychiatry

Dr Harry Freeman reflects on his long career.

In the 1970s my first year training in psychiatry was in a huge mental hospital in country New South Wales - there were ten such hospitals, all about 100 years old - sandstone, farm self-supporting, beautiful gardens - run by the nurses and only a couple of doctors.

A hospital house for working wife and baby (and Grandma), pay rise from $4,000 per annum as a similar RMO to $7000 as a registrar, ignorant, grandiose, political activist, anti-Vietnam, anti dominant paradigm, cocktail pianist, energetic and not hesitating. I felt good.

The hospital had four groups of patients, men and women in separate wards. So, as well as the mentally ill, there were alcoholics, dementia patients and those with intellectual and behavioural problems. Each group comprised about a quarter of the hospital population.

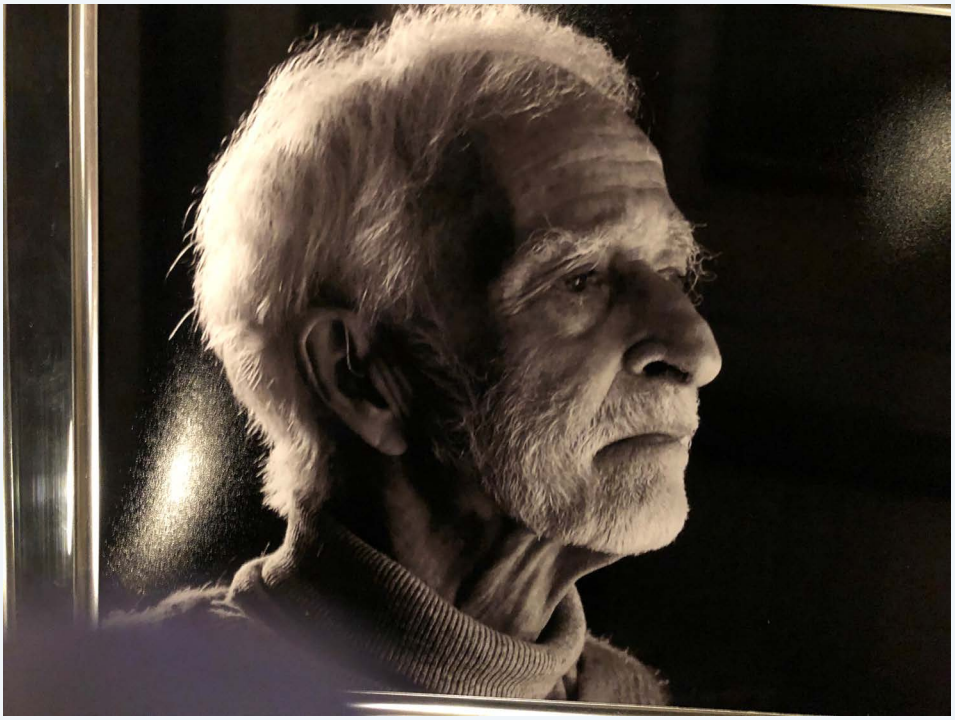
These latter groups filled the state's hospitals by the 1960s. Families no longer able to manage such people as the family dispersed and changed.

Despite more buildings, the hospitals were deteriorating, overcrowded and a Royal Commission in the 1950s determined that they shouldn't survive. A political and financial decision was made to do psychiatry in the community and in ordinary hospitals.

Creating so-called community mental health is a nonsense, given how many different sorts of humans there are in the communities within which we exist.

The dementia cases would be solved by creating subsidised and non-government nursing homes (predictably seriously problematic), the alcoholics got a few name changes and little else, and the handicap group are doing pretty well in "the community". The mentally ill are homeless and the drugs which help them in hospital didn't really solve their problems when out of it.

That is now, but in the 1970s, only 50 years ago, we still had the "mental hospitals", and I threw myself into seeing all the sorts of souls living there, with little supervision and lots of initiative and hope. I had a great year.



Long-time North Coast psychiatrist and accomplished pianist, Dr Harry Freeman. Photo: Jonathan Atherton

However the permanent staff were caring for patients who were very troubled by unmanageable moods and thoughts, despite treatment, rarely cured; many were troublesome, and many staff were quite demoralized.

I had particular responsibility for the dementia wards (there were few nursing homes then) and extended families were disappearing fast (so no carers for the elderly).

My job was to sign the death certificates (life expectancy was about two years from admission), review/increase medication, do physicals and keep a low profile. Nurses had run the place for the last 100 years.

These patients were in huge Nightingale wards, 50 each, 50 chairs around the day room; chairs with arms allowing a long sheet to be passed along them to restrain the patients, and another long sheet was under the chairs for ...

They were placed in these chairs for breakfast and spent the entire day there, usually needing help to feed (this being the result of the immobilization), doses of sedatives they required for sleeping, usually manacled, with little touch or conversation during the day, and then to bed.

An event I especially treasure was when I was holding an "existential group" in a chronic general ward of mostly mute, occasionally catatonic, paranoid cases when one of them who worked in the farm's piggery and who had not spoken for 15 years, grunted, during a silence, "But they're very good to the pigs". Then he stopped speaking again.

Another memory is of the med super dressing me down for seeing patients in their homes, keeping them out of hospital and discharging too many. This meant he was about to lose a cook because of dropping bed numbers, and in a country town an employed cook is much more valuable than a young doctor!

What did the social reformer, humanist, medico do about this situation where things were obviously seriously problematic? Absolutely nothing. I didn't notice what was happening, as my education, hard work, political activities and my family were more important. My capacity for selective neglect of major bits of my world, like for most of us, most of our lives, is infinite! Sadly the powerful and influential are similarly afflicted.

For the next four years I was training back in Sydney in a teaching hospital with all types of psychiatric patients, inspiring teachers and staff psychiatrists.

New initiatives appeared like rehabilitation, group work, behaviour therapies, outpatient clinics and Medicare-subsidised "private practice".

"Mental health" became a well-used term, despite us humans being unique, and what is healthy in some cultures may not be in others. However, mental illness is much the same everywhere in my experience, having worked here and overseas.

In 1974, qualified and having revelled in the Aquarius festival - sex and drugs and rock and roll - I joined my dear friend Igor Petroff who created the Lismore psychiatric service. We worked the area, doing clinics in Tweed, Grafton (including the infamous prison), Ballina, Casino, Murwillumbah and Lismore community mental health clinic. I was Robin to his Batman.

The 30-bed Richmond Clinic (there was only one psychiatric unit between Newcastle and Brisbane) took all sorts of patients who had previously been in the old mental hospitals.

Igor was permanently on call and was a good leader. The new team did much good and up-to-date work, and had excellent morale.

As the area's population expanded other units opened in Coffs Harbour, Tweed Heads, Kempsey and Byron Bay, with outpatient clinics and no more patients in mental hospitals.

The Richmond Clinic, slowly moving to the back of Lismore Base Hospital, now has wards for adolescents and older folk, but importantly men and women were still in the same wards, which is totally inappropriate.

The wards are as full as available staff allow, but recruitment is hard as the work can be challenging and sometimes quite dangerous.

There is little of the "asylum" In hospital psychiatry now as we oversell ourselves as being able to solve the problems of a rapidly changing society, where the problem of the dissolving extended family manifests, with our selling it with a "we'll fix it with mental health" or a call to Lifeline.

I'm ashamed that we are shunning public work, condoning a situation where the government is fixing problems by involving NGOs and pretending that the evident upsets so many folk are experiencing can be solved by fixing our individual mental health rather than addressing inequality, unfairness, loneliness, greed and anger, and "me rather than us".

Our drugs are little more effective than they were 50 years ago, though with fewer side effects. Big Pharma is a serious problem, investing less and less on drugs relevant to psychiatry. However, in truth there is a real problem with creating drugs that do affect our mental life predictably, since it is an amazing thing and care is needed.

We should be as worried about the legal drugs as about the illegal ones.

After 50 years I still have a love for psychiatry and I'm just as curious and puzzled by it as ever I was. I prescribe less, talk less, recognising that the most important therapeutic ingredient is creating a non-judgemental atmosphere in the consultation.

The odd grunt, if only as brief as the comment issued by the piggery assistant long ago, can be terribly important, not least to put a lie to those words penned by George Orwell - four legs good, two legs bad. The welfare of human beings must be at the forefront of all our work.

Whither the PHN?

continued from P7

are considering other ways of improving the health of their communities through their own efforts, sometimes with the help of the hospital sector.

Recommendation 3 of the Horvath review stated, "The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal."

This requirement was reaffirmed by the Ernst and Young report evaluating the initial performance of **Primary Health Networks in July 2018**: "PHNs to work with their Clinical Councils and other stakeholders to increase their engagement and reach with general practice and enhance general practice capability and capacity (e.g. through sharing best practice and lessons learned)."

It is over two years since this last review of the PHNs. This suggests the government is happy with how things are going since it only calls for such reviews when it wants change.

Karen Price, the newly elected President of the RACGP, is also looking to explore opportunities for service development outside the PHN structure and envisaged something more akin to the original Divisions of General Practice in her campaigning for the presidency.

The **Liberal Party believes** "that, wherever possible, government should not compete with an efficient private sector; and that businesses and individuals - not government - are the true creators of wealth and employment."

While many GPs and others might subscribe to this theory their lived experience is of more government intervention and control. Feedback from general practice is being ignored at all levels of government.

Borrowing from Chinese Communist Party terminology, one might describe this as "private enterprise but with Australian characteristics".

Year of the e-Rat

by David Guest

In the **Chinese calendar, 2020** was the year of the rat although some would argue it was the year of the **bat** or perhaps even the pangolin.

According to the calendar, the rat is the first of a 12 year cycle where each year is associated with an animal. There is also a superimposed elemental cycle (of which there are five) and 2020 was the first metal rat in 60 years. The rat is associated with the Northern winter and white, the colour of snow.

As befits the new era of a metal rat, 2020 saw major changes in medical communication technology. Most of what medical practitioners did continued as usual except everything now had an "e-" option.

Patients from many practices started to make e-bookings through one of several online commercial medical booking providers. Log in and find your favourite GP and book for her next available appointment.

The enthusiasm for using these providers was somewhat dampened mid year however, when **HealthEngine was fined $2.9 million** for breaching privacy regulations and tampering with online reviews and comments.

"E-check in" became possible through smart phone technologies such as Best Practice's **Best Health App**. Using "beacon technology" patients could register their attendance at the practice simply by entering the waiting room and checking in on the app. They did not need to formally check in with reception staff and the software notified both patient and practice that the patient was in the building with a "waiting status".

For those unable or unwilling to come to the practice there were "e-consultations". This was a life saver, at least in economic terms, for GPs and specialists. In general practice most consultations were performed over the phone due to the difficulties that many elderly patients had with mobile phones and computers. There were also a plethora of options for video consultations as **previously described by NorDocs.**

In the early days of the pandemic patients with fever or potential contact with COVID suspects did not make it into the consulting room. Car park consultations had a large "e-" element with much of the history obtained over the phone prior to the doctor masking up and going out to the patient's car. It was a nuisance and quite inefficient and most GPs are glad that the necessity for such consultations has greatly diminished in the last month.

"e-Scripts" surfaced briefly but their uptake was restricted by the Department of Health to hot spots, mainly in Victoria. They were however universally popular with patients and doctors. Instead of printing the script and faxing it off to the patient's preferred pharmacy, an e-script would be generated and an e-token for the medication was sent to the patient's phone or email address. The patient could then take the e-token to their pharmacy of choice where the QR code token was scanned and the medication dispensed.

Nearly all pharmacies in Casino, Lismore and Alstonville have the capability of reading the QR codes and doctors and patients are just waiting for the DoH to turn the system on for the North Coast.

"e-Pathology" was next cab off the rank. For many years, practices using Sonic systems have been sending an electronic copy of the request to the company at the same time as they generate a paper request. An e-pathology request can be sent to the patient by adding the word "Telehealth" to the clinical notes of the pathology form. This keyword then signals Sonic to send an SMS to the patient's phone that in turn links to a barcode which can be scanned by the Sonic collection staff. The paper copy can go straight in the doctor's bin.

"e-Radiology" also became an option but web based solutions that do not integrate with practice software did not find favour with GPs. Nobody wants to enter their own credentials and the patient's demographics into an online form.

"e-Authorities" also emerged during the year. Unfortunately once again it required jumping through too many hoops to get to the **HPOS application** and then selecting the correct patient and medication format. The potential for error is high and there is no negotiation for a script application that is refused. The only saving grace is that 3 month's worth of medication can be authorised if the application succeeds.

The most successful "e-med application" of the year was Healthlink's Smart Forms. Completing fitness to drive forms for Transport for NSW became much easier and more efficient for GPs and saved the patients a trip to Service NSW.

Smart Forms signal a new era in medical computing where separate databases populate a form with clinical data that is reviewed by the clinician before she signs off on the update of the patient's clinical status.

More widespread use of this technology will further enhance its usefulness and the Northern NSW Local Health District is using Smart Forms for sending patients to some of their outpatient clinics.

"e-Referrals" have been available for some years through the secure messaging providers, HealthLink, Telstra Health (formerly Argus) and Medical Objects. The functionality of the e-Referral system has been held back by interoperability issues and the absence of agreement between clinicians about how and when data is processed by recipients.

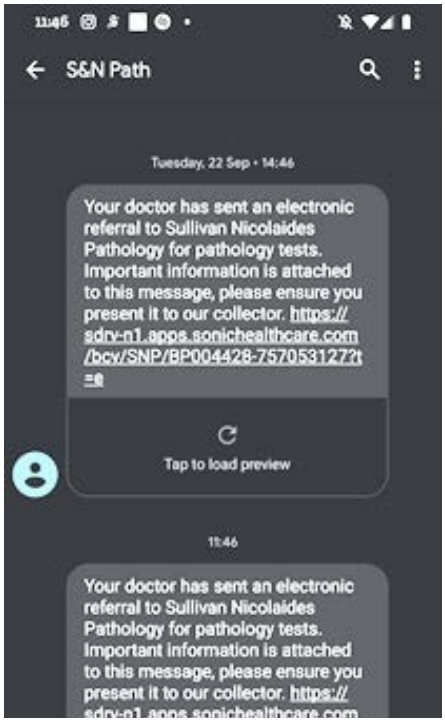
A local health district wide project to address this issue would improve patient care on the North Coast.

"E-med Ed" has flourished this year. Unable to gather together, even in small groups, education providers have embraced the online format. The RACGP, AMA, countless hospitals and even Nordocs have run their own programs.

NorDocs has held **four meetings this year** on the subjects of carotid vascular disease, new approaches to psoriasis management, the multi-disciplinary approach to breast cancer and an update on restrictive lung disease.

The organisation will continue with the program on a monthly basis from February to June next year before reviewing the viability and acceptability of further "e-meetings".

A year ago nobody had ever heard the term "COVID-19" but the year of the rat has been difficult for many, fatal for some and tried the patience of citizens and politicians around the country and around the world. The upending of traditional approaches to issues has stimulated developments in many areas and doctors have taken to heart the quote of Winston Churchill, "Never let a good crisis go to waste".



Book Review

by Robin Osborne

Untethered – A Memoir

Hayley Katzen
Ventura 367 pp

The 'untethering' of North Coast resident Hayley Katzen from her previous life began with migrating from South Africa in 1989, at the age of 22, and settling in Sydney to undertake a law degree. As she often reminds us in this introspective memoir she was - and of course still is - a white, middle-class, Jewish woman who had left a country with an racist and turbulent past, and an uncertain future.

Coming to realise she was lesbian represented another phase of her untethering from the conventional family and conflicted society within which she had grown up. Now, she could be free, not least sexually: "I'd cut my wild mane short in the hope I'd look more 'dykey' and find my place in Sydney's lesbian community."

Later, she headed north to the Northern Rivers, finding a lecturing job at Southern Cross University's Lismore campus and entering into the area's gay lifestyle. At a Tropical Fruits dance she met a woman "with deep brown eyes and a shaved head" who talked of 'truckies' knots' and lived in converted stables in the hinterland.

"Where the hell are we?", Katzen asked a friend driving her to the birthday party of Jen, the woman with whom she would form a loving and lasting, if at times complicated, relationship, largely because of their vastly different backgrounds.

This would be another untethering – moving in with a (wo)manual worker was way out of her cultural comfort zone: "My parents were middle-class Jewish professionals and intellectuals who'd never done a day's manual labour... Jen's broad and calloused hands were marked by abrasions from fencing, digging, gardening, building and cattle work."

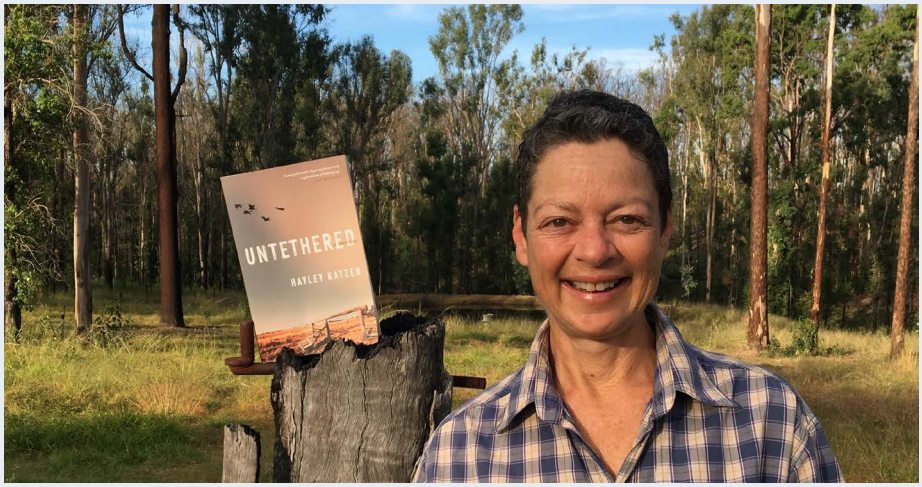
She recalls, "I'd counted four pubs and three butchers as we drove along the main street of the small country town."

"'Casino," the friend said, "The beef capital."

"Where even the radio station's named for cattle?" I said as I read out a billboard: COW FM".

In time Katzen adjusts to being an 'ex-city girl', bemusedly describing dinner parties where urbane friends recoil from Jen's stories of farm practices such as euthanising animals. She forms friendships with locals, realising that the years hadn't only "demystified life in the bush... [but] seeped under my skin along with memories of blackened fingernails and bruises, scars and splinters... This was what I knew now more than Shabbat dinners or city laneways."

Drawing on her legal skills she became active in the ultimately successful campaign against CSG mining, penning a lengthy submission to the state government, and, with her story turning full circle, participating in a 'Lock the Gate' float in Casino's beef week parade. By then she seemed well and truly untethered from her past life.



Gold Coast
PRIVATE HOSPITAL

GC Paediatric Surgery
CARING HANDS . COMPASSIONATE HEARTS

Dr Richard Thompson now consulting in Tugun

Dr Richard Thompson

BMed Sci, BMBS, FRCS (Paed.), FRACS

Paediatric Surgeon

Paediatric Surgeon Dr Richard Thompson is pleased to open rooms for consultation in Tiny Tots Paediatrics, Tugun.

Dr Richard Thompson is a specialist paediatric surgeon, experienced in treating a broad range of surgical conditions. Dr Thompson operates privately at Gold Coast Private Hospital and publicly from Gold Coast University and Tweed Hospitals.

He has extensive experience in both minimally invasive and open surgical modalities and is committed to providing exceptional care to the Coast's smallest patients and their families.

Dr Thompson specialises in:

- Common paediatric surgical procedures
  - Tongue Tie
  - Hernias
  - Undescended Testes
  - Foreskin Problems
  - Skin Lesions / Swellings
  - Haemangioma
- Gastrointestinal / Colorectal dysfunction
  - Constipation
  - Soiling
  - Anal fissure / Anal pain
- Diagnostic and Therapeutic Endoscopy
  - Endoscopy
- Coeliac Disease Diagnosis
- Emergency Paediatric Surgery
- Management of gastrointestinal and colorectal surgical conditions in chldren

To arrange an appointment for your patient, please contact

Southport
Gold Coast Private Hospital
Suite 15, Ground Floor
14 Hill Street, Southport 4215

Tugun
Tiny Tots Paediatrics
John Flynn Specialist Suites
Suite 602, Level 6
42A Inland Drive, Tugun 4224

Phone: 07 5530 0492 | Fax: 07 5530 0686 | Email: info@goldcoastpaediatricsurgeon.com.au

Telehealth 'revolution' to continue into 2021

Millions of Australians will continue to receive medical care and support in their own homes with the Morrison Government investing more than $2 billion to extend a range of COVID-19 health measures for a further six months, to 31 March 2021.

Medicare-subsidised telehealth and pathology services, GP-led respiratory clinics, home medicines delivery, public and private hospital services will all be extended, as well as further investments in PPE. These health initiatives play a major role in detecting, preventing and treating COVID-19.

Prime Minister Scott Morrison said the $2 billion extension in funding brought the Government's commitment for the COVID-19 health response to more than $16.5 billion since March 2020.

"We will continue to provide Australians with critical health care and support to protect both lives and livelihoods," the Prime Minister said.

"By providing telehealth and home delivery medicine services we are reducing the risk of exposure to COVID-19 in the community while also supporting people in isolation to get the care they need.

"Importantly this also includes mental health services, delivered over the phone, by trained specialists and GPs.

"As we continue to suppress COVID-19 while continuing to open our economy up, Australians can be reassured that we have the world's best medical support in place to protect their health."

Minister for Health Greg Hunt said "Our Governments response to the pandemic brought forward a 10 year plan on telehealth within 10 days."

"As a consequence, over 30 million consultations protected the health and wellbeing of Australians, and protected our health workers and the viability of their practices."

Patients will continue to have access to Medicare-subsidised telehealth for general practitioner, nursing, midwifery, allied health and allied mental health services, where and when they need them.

Telehealth is also being extended for essential specialist services, such as consultant physician, geriatrician, and neurosurgery services. Bulk billing will continue to be available and regular billing practices will apply to all of these services.

Up to 150 GP-led respiratory clinics across the country, which complement state run fever clinics, will continue their pivotal role in testing. Patients will continue to have access to bulk-billed COVID-19 tests under Medicare, with aged care residents and staff getting priority access to rapid testing.

Medicare-subsidised pathology and testing at the point of care will continue in 86 rural and remote Aboriginal and Torres Strait Islander communities in Western Australia, the Northern Territory, Queensland, South Australia, New South Wales and Victoria. This enables early identification of cases and rapid response if COVID-19 is detected in these highly vulnerable communities.

Eligible people will continue to get free home delivery of essential medicines by their local pharmacist. The Home Medicines Service has already delivered more than one million medicines to patients' homes at no additional cost to patients.

Our support for states and territories continues, with the historic National Partnership Agreement ensuring the public health system is prepared and the public and private hospital systems are fully resourced and able to respond rapidly to any outbreak.

As an example, this agreement has enabled the transfer of more than 480 aged care residents to private hospitals and deployed clinical and nursing staff to assist in aged care during Victoria's second wave.

The National Coronavirus Helpline will continue to operate around the clock providing important advice.

The expert Australian Health Protection Principal Committee recognises that future outbreaks will occur. The ongoing health response must be maintained to protect the health of Australians.

◊ ◊ ◊ ◊ ◊ ◊ ◊

The Federal Government will extend subsidised telehealth sessions for an extra six months, as part of a $2 billion top up to keep COVID-19 health measures going during the pandemic.

Key points:

• The telehealth scheme was due to finish at the end of this month

• More than $600 million was initially set aside for it by the Government in March

• The Prime Minister said the extra money brings the Commonwealth's investment in coronavirus health responses to $16.5 billion

The additional funding will ensure Medicare-subsidised telehealth for general practitioners, nursing, midwifery, allied health and allied mental health services will continue until 31 March 2021.

Health Minister Greg Hunt said the scheme, implemented when the pandemic first took hold, has been a "revolution in health delivery".

"It was borne from necessity but it's delivered better health care for over 30 million consultations so far," Mr Hunt said.

"In particular we know it's been used for over 18 million regular consultations by general practitioners.

"It's kept the patients safe, it's kept the nurses safe, it's kept the doctors safe," he said.

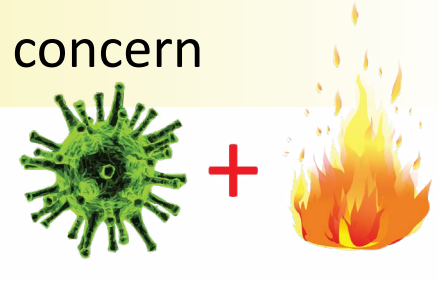
More than $600 million was initially set aside by the Government in March to expand Medicare subsidies for telehealth services, allowing Australians to have consultations with a range of health professionals via video and phone rather than attend appointments in person.

The scheme was due to lapse at the end of September.

Telehealth for "essential specialist services", such as consultant physician, geriatrician, and neurosurgery services, will also continue with bulk billing and regular billing practices to apply. Mr Hunt said the package would also support the maintenance of other coronavirus health measures.

"There will be support for home medicine delivery, continued free COVID-19 pathology tests, as well as further personal protective equipment, respiratory clinics and the state and private hospital partnership agreement," he said.

Psychological issues still our commonest concern



As they have been for several years, psychological issues, including depression, anxiety and sleep disturbance, continue to be the leading reasons for seeking GP care, with the RACGP saying Medicare subsidies should be made available for longer mental health consultations, enabling patients to be better supported to talk to their doctors.

This year's **General Practice Health of the Nation report** found 64% of GPs reported these as the commonest reasons for patient presentations, exacerbated by a horror year for the healthcare sector. The impacts of the 2019-20 bushfires and the COVID-19 pandemic were immediately apparent in the feedback from GPs.

According to Acting RACGP President, Associate Professor Ayman Shenouda, GPs themselves were also affected, with more than half of those surveyed reporting that the pandemic had a negative impact on their wellbeing, with 27 per cent saying their mental state had actually deteriorated.

The second most common reason for GP presentations – seeking preventive healthcare support – changed dramatically from the 2019 survey, increasing to 56% from the previous 18%. The report attributed this to the greater number of flu vaccinations provided in 2020 compared to other years: "The Australian Government... encouraged all Australians to get vaccinated early to avoid extra stress on the health system during the COVID-19 pandemic."

The online survey for the report was undertaken during May 2020 and engaged 1782 respondents, 62% of them female GPs and 73% in major cities.

The nation's healthcare challenges are "only set to grow in the wake of the pandemic," the report noted.

"The long-term effects of the pandemic and the bushfires are going to be severe ... and the recovery phase will take years... Continuity of care is vital to improving patient health outcomes and reducing hospitalisations."

It added, "Medical experts and policymakers have long called for a voluntary patient-enrolment model to help coordinate access to multidisciplinary care. Such a model would support GPs and practice teams to better manage chronic disease and mental health issues.

"The irony of our health funding is that the majority goes to acute care in hospitals rather than preventing patients going to hospital in the first place," Prof Shenouda said. "This is a recipe for disaster."

Concluding "There's no turning back" when it comes to Medicare subsidies for telehealth services, the report noted "patients and GPs have seen how valuable these services are. If Medicare subsidies were available for longer mental health consultations, patients would be better supported to talk to their GP about what they're experiencing."

Prof Shenouda said, "GPs are among the heroes of the bushfires and pandemic. They've demonstrated a resilience, adaptability, positivity and empathy that's nothing short of inspiring."

Has a superfood become an enviro-vandal?

by Robin Osborne

The fruit commonly associated with Coffs Harbour is the banana, plantations of which have covered the steep hillsides fringing the North Coast town for decades. So celebrated was the crop that it spawned one of Australia's roadside attractions known as the 'Big Things'.

Now, changing times and tastes have created a market for a more valuable fruit, the blueberry, a native of North America, and netted plantations have rapidly taken over much of the land previously under bananas.

National Marine Science Centre researchers Shane White (left) and Praktan Wadnekar. Photo: SCU

The industry, like its banana forebear, is dominated by industrious farmers of Sikh Indian background – Woolgoolga hosts the biggest Sikh temple on the east coast, and the State MP is of Sikh heritage.

It is hard to imagine the construction of a 'Big Blueberry', especially as the Big Banana Fun Park has been upgraded in recent times, but the popularity of the 'superfood' continues to grow.

While the 'anti-inflammatory' berry may indeed lower our risk of heart disease and cancer it appears that its impact on the environment – depending on the growing site – may be less than healthy. This is the initial conclusion of research by Southern Cross University scientists who are working with the NSW Government's Clean Coastal Catchments initiative and in collaboration with Monash University.

The study's focus is on local water quality and the impact of blueberry cultivation on steep slopes experiencing high rainfall and it has put the industry under an environmental cloud because of nitrogen runoff into creeks that drain to the famed Solitary Islands Marine Park.

Concerned Coffs locals have begun buying into the issue, with a resident telling The Sydney Morning Herald, "Blueberry farmers have walked roughshod over us, their neighbours, for years, spraying chemicals that run off into creeks, setting off loud noises to scare birds and operating deafening wind turbines so the frost won't settle on the fruit.

"One wonders what will happen to these eyesores when the bottom falls out of the blueberry market and the soil is so contaminated that nothing else will grow there."

The market is already under threat, according to farmer Iqbal Singh Grewal, who told the paper that while the industry is improving run-offs its finances are turning sour.

"His farm switched to blueberries about five years ago after banana profits dwindled," the paper reported, but "It costs Mr Grewal's farm about $20 to produce a 1.5 kilogram tray of blueberries that he can sell for $21.50 if he's lucky."

The farmer added, "Everybody's growing blueberries around Australia," from the Atherton Tablelands down to Tasmania.

'Fruitologist' Alex Coronakis from Tropicana

But the local industry is the one that – so far, anyway - has attracted attention, with Coffs Harbour City Council commissioning SCU to investigate the environmental impacts of the industry.

A 2018 study had found levels of nitrogen soared after rains as fertiliser from farms washed into rivers, reaching 695 times that of drier conditions –

"These [nitrogen oxide] loads were amongst the highest reported for catchments on the east coast of Australia, and similar to loads in rivers throughout China, Europe and India with strong agricultural or urban influences"

Shane White, a PhD researcher at SCU's National Marine Science Centre, said, "These waterways remove nearly all the nitrogen during dry conditions, but lose the ability during rain events when large amounts of nitrogen in creeks can escape to the coast."

Hearnes Lake, between Coffs Harbour and Woolgoolga to the north, is the last naturally-occurring filtration defence before catchment run-off enters the iconic Solitary Islands Marine Park.

"About 50% of the nitrogen is sourced from fertilisers, and the rest from treated sewage in the Hearnes Lake catchment. Management of both sources is necessary," Mr White said.

"Treated sewage is released to the farms to irrigate the crops and is relatively easier to manage but fertilisers are more widespread and complicated to manage."

Praktan Wadnekar, also a PhD researcher at the NMSC, was the lead author of one of the latest reports.

"Nearly all creeks with agriculture and urban land use had water quality issues. Hearnes Lake, Woolgooga Creek and Coffs Creek are the main areas of concern," said Mr Wadnerkar.

"We are working with farmers, industry and government to improve on-farm practices and provide a framework to protect the waterways from harm," Shane White said.

continued on P16

Here today - gone today for joint surgery patients

A program piloted at Grafton Base Hospital from September is enabling day-only hip and knee replacements for local patients. In what may be a first for the Australian public hospital system, advanced surgical and anaesthetic techniques and better postoperative pain management have reduced the length of stay for patients having major joint replacements, when clinically safe and appropriate.

Dr Sam Martin, orthopaedic surgeon and program lead, said the pilot program, expected to run for six months, is based on research that suggests patients can have successful outcomes given the right care and support in their own home, without the added stress of a hospital stay.

"There is compelling evidence that for many patients, a day stay joint replacement is safe, with equal or better results compared to a longer hospital stay, in terms of the patient's return to function," Dr Martin said.

"We also know that getting moving again soon after surgery is shown to reduce the recovery time for patients. Within 3-4 hours of the surgery, under the care of our physiotherapy team, patients can begin moving and will remain in hospital for at least six hours before they go home.

"This is a significant achievement for a small regional centre like Grafton. This program is really the culmination of an outstanding team effort, from surgeons and anaesthetists, to nursing staff, and allied health staff who support the patients before and after surgery."

Up on their feet... patients Susan Robertson Halil and Sandy Van Veluewen were the first to receive surgery through the new program.

Many aspects contribute to a successful day-stay total joint replacement, including a streamlined preoperative physiotherapy and education program, a focused operating theatre unit, tailored anaesthetic and surgical techniques and nursing by staff skilled in shorter stay surgery.

"Patients will be supported through telehealth and face-to-face specialist care to review pain management and wound recovery, and also have regular physiotherapy sessions in the weeks following their surgery," said Dan Madden, General Manager Clarence Health Service.

Has a superfood become an enviro-vandal?

One critic is Sally Townley, a Coffs Harbour City councillor, who said land clearing could be added to the "litany of issues" generated by the industry, not least because farmers don't need to lodge a DA for so-called intensive plant agriculture under the local environmental rules: "Almost every other form of development requires consent," Dr Townley said.

"So if you want to build a house, shed, pool, et cetera, you apply for consent via a DA."

Key recommendations of the SCU study include:

• Planting native vegetation on both sides of creeks to reduce the amount of nitrogen entering the creek.

• Install tailwater catchment ponds on farms to catch the high water flows and slowly release this water to the creek.

• Reassess the use and suitability of nitrogen-rich recycled sewage on farms in coastal catchments.

Where has all the taste gone?

Bluntly put, most blueberries sold in Australian supermarkets are small in size and taste bland, at best, or even sour. They are part of a species-wide trend in fruit and vegetables produced for the commercial market. Strawberries have become bigger but are almost always sour, while 'tasteless tomatoes' are often the modern norm.

Chasing answers I approached long-time 'fruitologist' Alex Coronakis who runs Tropicana in Lismore's central Keen Street. First, he offered me a taste of what he regards as the best blueberries on the local market, grown not on the steep hillsides around Coffs Harbour but in the red soil of nearby Wollongbar by one of the region's best-known horticulturalists (and philanthropists), Ridley Bell.

Mr Bell is a farmer par excellence who has worked on improving the size – the Big Blueberry, indeed - and the taste of his crop through DNA enhancement. There is no doubt that his product is superior to that commonly sold in the major stores (although some of it does find it way to supermarket shelves), and at nothing more than a slight premium price increase.

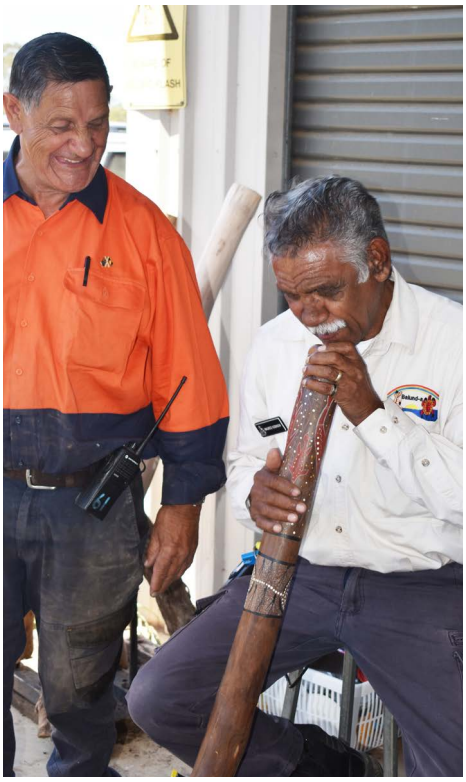
Clearly, a high-quality product can be produced, and without a deleterious impact on the environment.

Further south, the future of the Coffs Harbour blueberry industry lies in the hands of the scientists, the regulatory authorities and ultimately, in the hands of the growers. Let us hope that a favourable resolution can be found.

The ancient 'didge' helps with modern challenges

Researchers have suggested the didgeridoo may be the world's oldest musical instrument, and while ancient cave paintings that show it have been dated to between 3000 and 5000 years ago, its history may be at least 40,000 years old.

Nowadays, in an innovative diversionary program for Aboriginal male offenders near Tabulam on the Upper Clarence River, making and mastering the classic indigenous instrument has become a therapeutic skill aimed at boosting wellbeing and reducing re-offending for a high-risk population.



Michael Cain, Facilitator with Elder, Uncle Buck

The focus of the Balund-a program is enhancing life skills within a cultural and supportive community environment. It is located on a working cattle property offering many other skills and programs, including literacy and numeracy, addiction and stress management, parenting skills, small motor skills, and more. Much emphasis is placed on cultural activities such as art classes, hence the role of the famous didgeridoo, an artwork as well as an instrument.

Traditional techniques are taught after finding the special timber that has been collected in remote western NSW. Mostly this is Mallee, Box, Mulga and Coolabah, found where termites have eaten out the centres. These cylindrical logs are transported to Balund-a's workshop where the residents are taught the techniques of didge making.

From the raw timber, the next process is stripping the bark. Then they are sanded well and lacquered. The mouthpiece is made from beeswax. Each didge ends up with its own unique sound. The project facilitator is Michael Cain, supported by local Aboriginal Elders Aunty Muriel and Uncle Buck.

A recent presentation ceremony during NAIDOC week was accompanied by traditional dance as well as some impressive didge performers. Cultural skills are so important to lift the spirit of those in custody as they prepare to return to their families and Country. Such diversionary projects help with the healing process of mind and soul and open the way for a brighter future.

Balund-a provides important programs to help with the transition for inmates from jail back into their community. Health and mental wellbeing after release are vital to help reduce the recidivism rates and this didge project has clearly demonstrated its role in cultural connection.

This project was funded by Arts Northern Rivers and donations are being sought to ensure this project continues. Donations over $2 are tax deductible and can be made by contacting Arts Northern Rivers on (02) 6621 4433 or **info@artsnorthernrivers.com.au**

Humans, Animals and Covid19: a two-way street (or roundabout?)

By Mike Fitzgerald,
Veterinarian, Alstonville.

American Mink - White by felixd, CC BY-SA 4.0, via Wikimedia Commons

As I write this the total number of confirmed cases of SARS-CoV-2 / Covid19 in the species Homo sapiens sapiens is 66,868,965, with 1,430,389 deaths. Given a global population of 7.8 billion, that's approximately one death per 5,500 people.

Ours is not the only species susceptible to infection with Covid-19. This article attempts to describe what that might mean for us and for other species.

Just as the dromedary camel was susceptible to MERS, some other mammal species have structurally similar binding sites for Covid19 (aka SARS-CoV-2). These are primarily the angiotensin-converting enzyme 2 (ACE-2) receptors in the lungs, to which the SARS-CoV-2 spike proteins attach. Similar binding sites means that these species can potentially be infected with it. (Although fewer of these mammal species are similarly affected by it due to different host immune responses.) The consequences of this fact have several aspects:

Firstly, there's the risk of zoonotic (animal to human) spill-over from an intermediate host, as was recently seen in Denmark with a dozen human cases of infection with a Mink mutation variant of SARS-CoV-2.

Secondly, there's the risk of human to animal transmission to a susceptible species, some of which are endangered. The Leakey Foundation has warned of the potential risk of SARS-CoV-2 to non-human primate species in zoos, research facilities and most importantly in endangered wild populations. Apes and all African and Asian monkeys are identical to humans at all of the binding sites, so they are likely as susceptible to SARS-CoV-2 as humans are. Some of these critical primate species number in the thousands and could face extinction if infected.

Thirdly, there is the risk of the establishment of reservoirs of SARS-CoV-2 infected species in the wild. This could make future control and elimination of the virus from human populations difficult. A species called *Neovison vison*, the European farmed Mink, hasn't fared that well.

Mink are carnivorous semi-aquatic members of the mustelid family, which also includes otters, ferrets and weasels. They are farmed intensively for their fur in Northern Europe, North America, Ireland and Russia. Mating occurs in March, and after a life spent in cages under controlled lighting, those not needed for next season's breeding are killed by gassing with carbon monoxide about nine months later for their pelts - so that we can exercise our God-given right to look like a 1930s bootlegging mobster or Marilyn Monroe in Gentleman Prefer Blondes. (Memo to H. sapiens: "we can do better").

In September 2020, in Jutland Denmark 12 human cases Covid19 were found to be caused by a mink-derived variant of SARS CoV-2. This variant was colourfully named the "Cluster 5" mutation. The cases ranged from ages 7 to 79, with all having links to the mink farming industry. The Danish authorities were concerned that this had potentially serious implications for diagnostics, therapeutics and vaccines.

On November 5 the Danish Government ordered that all Danish mink must be culled (i.e. gassed en-masse and bulldozed into mass graves), a total of 17 million, give or take. A political storm ensued, which ultimately led to the resignation of Denmark's Agriculture Minister, largely over the fact that there was no legislative basis for the decision.

So far, the "Cluster 5" mink Covid19 mutation has not proved dangerous and seems to be a dead-end in people because it hasn't spread. However, it caused concern because variations in the virus spike-protein region could affect the immune system's ability to detect the infection. Many vaccines also train the immune system to block the spike protein.

The end-result was that the 17 million dead mink were collateral damage. [Sickeningly, many culled mink were soon 'rising from the grave', as their gas bloated bodies caused the shallow burial pits to burst from the ground https://www.theguardian.com/world/2020/nov/25/culled-mink-rise-from-the-dead-denmark-coronavirus]

Carl Linnaeus named our species *Homo sapiens* in 1758 (from Latin, sapiens the wise). Alternatives might be *Homo hubris*, *Homo imprudentis* or *Homo arrogans*. It is probably too early to tell which is the most suited.

Self-management can help reduce men's PMD

by Andrew Binns

You may have heard the saying "no matter how hard you shake it the last drop always goes down your leg". This is the condition called post-micturition dribbling (PMD), common amongst men "of a certain age" that probably does not get the attention it deserves. It can cause considerable distress and even result in the need to change wet underwear - or even conceal wet outer-wear.

For men, gravity and muscle weakness are responsible for urinary dribble. The male urethra does not run in a straight downhill line. It has a little dip in the middle of it, creating a pool where urine can collect. Normally, a muscle called the bulbocavernosus that fits around the urethra will automatically squeeze to force the urine out, but this muscle can lose its tone, especially in men older than 50 years.

Sometimes movement and gravity will cause the last few drops of urine that pool up in the dip of the urethra to involuntarily spill out of the body at an unpredictable time, leading to those embarrassing wet spots.

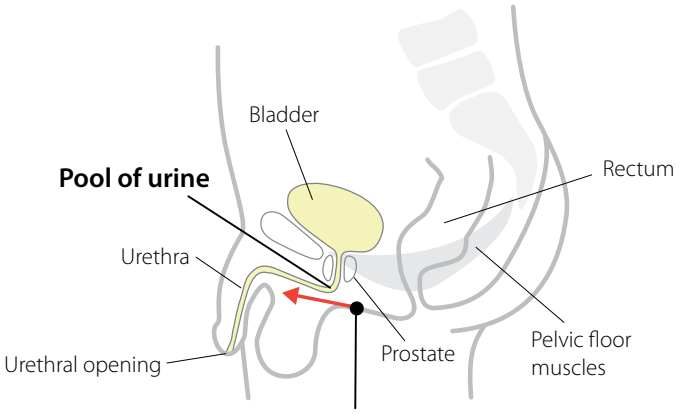
The statistics vary on how common this condition is, with some studies suggesting it may be over 50% in older men. It certainly increases with advancing years. In an ageing population it is growing in prevalence and is often associated with other lower urinary tract symptoms (LUTS) and sometimes with erectile dysfunction (ED).

The amount of urine lost is variable. One study shows that in those experiencing ED the leakage was approximately 2.1 mls, compared with 1.2 mls for those not having ED.

PMD can occur in women but less commonly. A good and recent review article of many studies on this topic can be found in the Journal: Investigative and Clinical Urology 2019 May; 60(3): 142-147 titled, **A current perspective on post-micturition dribble in males.**

The abstract of this paper states:

"Post-micturition dribble (PMD) is the involuntary loss of urine immediately after urination. It is classified as a post-micturition symptom and is more common in males. Traditionally, PMD has been considered part of the aging process, to have a low prevalence, and to be less bothersome than other lower urinary tract symptoms (LUTS).



"However, recent evidence suggests that PMD is not less common and does not elicit less discomfort compared with other LUTS in males. Also, PMD seems to commonly overlap with other LUTS and to be associated with erectile dysfunction. Although the etiology of PMD is not fully understood, a weakness or failure of the pelvic floor muscles is considered the most important factor. Although bulbar urethral massage and pelvic floor exercises are known to be effective in treating PMD, pharmacologic treatment has not yet been introduced. Recently, the possibility of treating PMD with phosphodiesterase-5 inhibitor has been suggested."

When it comes to GP management an appropriate medical history and examination is the first step. Depending on the findings a referral to a Urologist may be indicated.

"Bulbar urethral massage is usually of some benefit..."

In regard to treatment there are few options and the benefits of pharmaceutical intervention is still not conclusive. However, there is one simple self-help procedure that can be taught to patients - bulbar urethral massage. It is usually of some benefit and can complement the encouragement of pelvic floor exercises.

The technique for this bulbar urethral massage instructions for patients is as follows (see accompanying diagram):

- Pass urine in the usual way then wait a few seconds to allow your bladder to empty.
- Place the fingertips of your hand about 3 finger widths behind your scrotum and press gently.
- Still applying pressure, bring your fingers towards the base of your penis.
- This pushes the urine forward from the bulbar urethra into the penile urethra where it can be emptied by shaking or squeezing in the usual way.
- Repeat this process twice to ensure that the urethra is completely empty.
- Practise this technique at home
- When in a public toilet it may be advisable to use a cubicle for more privacy. (see diagram).

Note: this procedure can be done through clothing which may be more acceptable for men standing at a urinal.

In conclusion, PMD is often ignored as just being on the list of inevitable problems as one grows older. It probably deserves more attention and research to find improved treatments. Maybe there will be medications that help in the future, but meantime this simple self-help management of bulbar urethral massage along with pelvic floor exercises has a vital role to play.

No news wouldn't be good news

Robin Osborne runs an eye over the regional media outlets that have emerged since the demise of the Murdoch-owned newspapers.

Once upon a time the classified ads for jobs, cars and much else weighed down the metropolitan Saturday papers and poured 'rivers of gold' into the coffers of the proprietors, notably the top-end titles owned by the Fairfax and Syme empires.

Their demise at the hands of online listings such as realestate.com and carsales.com came quickly and comprehensively, and mastheads such as The Age and The Sydney Morning Herald took huge hits, now struggling to survive. Before many more years have passed they are likely to be solely digital products.

Even the mass tabloids, e.g. Sydney's The Daily Telegraph and Melbourne's Herald-Sun, are starting to struggle, while in most regional areas, notably northern NSW, the tabloids, free and otherwise, have vanished altogether.

On June 27, after 144 years of publishing, the Lismore-based The Northern Star printed its last edition. Gone the same week were its many sister publications, Tweed Daily News, Grafton's Daily Examiner, Coffs Coast Advocate... the list goes on and includes popular suburban freebies such as the Ballina Advocate, Lismore Echo, Byron Shire News, Richmond River Express Examiner.

Because they were free did not mean they lacked quality, nor were not valued by their readerships.

To say that residents were disappointed by this corporate slashing is putting it mildly, outraged would be more accurate, but the Murdoch empire has never been moved by community outrage – as Kevin Rudd reminds us as he progresses his petition to parliament in an attempt to encourage a Royal Commission into the political bias and dominance of NewsCorp's media in Australia.

So much for the bad news. On the positive front, a range of local media outlets has been consolidating their market presence, whether offered without cost to readers, as with the long-established Byron Shire Echo and its daily Echonetdaily email feed, the informative and widely distributed Nimbin Good Times, or several publications that have lined up to fill the gap left by the defunct tabloids.

Newcomers include the glossy Northern Rivers Review, owned by well-heeled Antony Catalano, former CEO of real estate online Domain.com who bought Australia Community Media from Nine for $125M. It is edited by Sophie Moeller, former editor of Murdoch's Lismore Echo, and in keeping with the new boss's roots, has a strong real estate focus.

The Review has a $2.00 cover price, as does the "locally owned and independent" Northern Rivers Times, a weekly that was initially free, which is more news oriented and has an ambitious Tweed-Clarence footprint. So far its page numbers are holding up well, confirming that residents miss local print coverage, although ideally more closely focused on their own LGA.

Addressing this need is the Richmond River Independent, the only paper that has directly replaced its predecessor (the Express Examiner), both geographically – based in Casino, and covering the broader Richmond Valley LGA – and with the same editor, the well regarded Susanna Freymark.

Shakier, and perhaps too quick to enter the fray, was the weekly Local Newsroom Northern Rivers, also priced at $2.00, that seemed to be disappearing at the time of writing. Liquidity was apparently a major problem.

More buoyant is the Lismore App, which has wider coverage than the name suggests. This online free subscription news outlet has been downloaded to 26,500 phones and tablets, and is averaging up to 60,000 views per week, according to managing director and digital content editor, Simon Mumford. Staff include an advertising rep, a sports editor and experienced journalist Liina Flynn who told us the app is aiming to be "a true alternative to the Northern Star."

The Star, it might be noted, can be accessed behind a paywall upon subscription, as can a few others in the Murdoch stable, but content is limited. Some of its stories also run in The Daily Telegraph during the week.

Divided into a range of categories – News & Sport, Weather & Travel, Takeaway/Home Delivery etc – the Lismore App is functional, kept updated, and has now been emulated in Orange and Port Macquarie. Furthermore, thanks to strong advertising support, it is truly free, which only a few local outlets, notably the Byron Echo and Nimbin Good Times, can match.

There is no doubt that ditching their community papers has done nothing for the Murdoch organisation's image, and very little, one would think, for its bottom line, as most of them, especially the freebies, seemed to be doing well, albeit hit by the COVID-19 downturn.

However, out of challenge comes opportunity, and it is to the credit of local communicators and entrepreneurs that they are exploring ways of keeping the community in touch with what is happening.

Our thanks should also go out to the region's free electronic outlets - the ABC in all its guises, the many commercial and community radio stations, and free-to-air television with its local reporters and nightly bulletins. Without them the North Coast would be less informed and culturally poorer.

Editor Robin Osborne has worked for and contributed to a range of media organisations, and is a former editor of the then-independent Lismore Echo and Northern Rivers Echo.

Every picture tells a story

Robin Osborne reviews a narrative art project where healthcare patients met TAFE students to go on a personal journey through sickness, healing and self-discovery.

Above: The Silk Road by Mark Alcock is not, despite appearances, an aerial view of landscape.

The dramatic image is surely an aerial view of landscape, perhaps an Aboriginal work characterised by the 'helicopter' view commonly seen in Central Desert paintings. The low hills, tinged red-pink by early morning or afternoon sun, are fringed by a body of dark water, the thick swirls of blue and red paint applied dramatically.

Yet the painting's title, The Silk Road, bears no relationship to Australia... or so it seems.

Rather than looking externally for inspiration the artist, TAFE student Mark Alcock, gazed inside the body for inspiration, portraying the devastating impact of an auto-immune disease named Behçet's Disease on a local man who had battled this condition for years.

"P shared a tale of woe that began towards the end of 2017 and continues to this day," writes Mark in the artist's statement, or 'Student's Reflection', that accompanies the work.

"He tells me it is a condition discovered along the old Silk Road... [it has been] a medical odyssey that began with ulcers and later traversed numerous other issues over time [often from the secondary effects of treatments for the oropharyngeal ulcers]... rashes, oral thrush, sepsis, malnutrition, dehydration, joint aches and kidney issues.

"My artwork looks at a physical manifestation of the condition (as ulcerated tissue) and works it into a landscape reflecting both the idea of the Silk Road and the patient's tour of the Australian East Coast undertaken in search of medical help."

The patient had been receiving care in Ballina District Hospital (BDH) under the supervision of staff specialist Dr Tien K Khoo, co-curator of the exhibition 'Unconditional Stories' with Tracey Beck, a Diversional Therapist* with Northern NSW Local Health District, and TAFE Lismore Teacher of Visual Art, Steven Giese.

"My life has been a 'treadmill of misery' with an autoimmune disorder," P says.

"I woke up on Christmas Day with a mouth ulcer which multiplied... I get ulcers in my throat and lips. They are very painful and can appear overnight. If severe, I am kept awake drooling through the night. My immune system is shot and my skin is paper-thin from prolonged steroid use. I have had 50 hospital admissions in the last 3-4 years. My last admission was for sepsis and I have had multiple pneumonias. It's only cleared up once since it all happened.

"I was a fitter and turner by profession. Before, I did lots of outdoor activities like swimming and surfing. I enjoyed a healthy lifestyle previously. It has turned my life on its head. It's hard on the kids and had a big impact on my relationship. At times, I felt disempowered and have felt institutionalised. It's a painful mystery."

The show's concept was to match ten former BDH in-patients with Diploma of Visual Arts students - one male, nine female - who would encourage them to share details of their lives and illnesses. Then the artists would create works representing the patients' experiences of their journeys.

As Tracey Beck explains, the original plan was to arrange face-to-face meetings between subjects and artists. Then COVID-19 came along. Arranging video conference calls was the next option, but when that seemed impractical, one-hour phone calls were held, meaning the artists had to undertake their work sight-unseen. Portraits or visually identifiable pieces were not allowed for confidentiality reasons, although human figures are present in some of the works.

Suggested questions to be asked of the patients included, "In your words can you tell me about your main illness or injury that led to your recent hospitalisation?," "Can you describe how you felt when you were unwell? What symptoms did you experience?", "What were your thoughts or feelings at the time?", "Has your day to day living or quality of life been impacted?", and "Do you have any advice you would like to share with anyone else who might be going through a similar experience?"

Pictured (l-r) Visual Art teacher, Steven Giese, Diversional therapist Tracey Beck and Dr Tien K. Khoo.

Every picture tells a story

continued from P21

First names were used in the interviews, later de-identified for the exhibition. As would be expected, medical conditions varied, from the little understood Behçet's Disease through to Diabetes, Stroke, Osteoporosis, Parkinson's Disease and falls injuries ("I slipped on a pine cone and fell. I didn't know that my femur was fractured until three days after the accident.")

Most patients were elderly, with the oldest participant having notched up 94 years. Needless to say, the artists were much younger, and they were clearly affected by the experience.

Writes Monique Jerome about her accomplished seascape Gra-Gra's Story, "G has always been drawn to the ocean, Shaw's Bay in particular. He has a natural affinity with the ocean and speaks fondly of regularly going crabbing, snorkelling, fishing and walking on the beach daily with his partner and their family. My oil painting in response to G's story captures the ocean environment that brought him so much pleasure before the onset of Parkinson's."

Juliette Rengel's painting *In sickness and in health*

The organisers of this innovative show are rightly proud of the outcome, which ran for over two months at Northern Rivers Community Gallery in Ballina and was visited by hundreds of locals and visitors.

Described as a meeting of medicine, art and education, the exhibition forms part of a broader inquiry into the importance of empathy between patients and the healthcare system that is being conducted by Dr Khoo, who has a special interest in neuro-degenerative issues and a research association with University of Wollongong and Griffith University. Tracey Beck, the Northern NSW Local Health District's only Diversional Therapist, is also closely involved.

The project goes well beyond 'art therapy', as the patients are not the artists, although they are benefiting from seeing their experiences reflected back to them in visually creative ways. The artists, in turn, have undergone experiences not anticipated in their studies, meeting – albeit virtually – with strangers, learning to conduct interviews, and hearing stories that were often well outside their comfort zones.

Both sides of the equation agree that the results were extraordinary, and to remind patients of their experience they were provided with prints of the exhibited artworks. The originals will go on permanent display in the corridors of Ballina District Hospital, with the outcomes of the project being incorporated into a research paper under development by Dr Khoo and Ms Beck.

Ridding Papua New Guinea of smoking

The full-length version of this story and a variety of his collected Work and Other Travel Tales (2018) can be viewed at **this link.**

by Dr Simon Chapman

In 1983 I received a call from the late Nigel Gray, then head of the Anti-Cancer Council in Victoria and also the director of the International Union Against Cancer's tobacco control program. He asked me to join him and two others, Gary Egger and Paul Magnus, on a visit to Port Moresby where we were to try and convince the government to ban all forms of tobacco advertising.

Proposals to do this had been discussed since 1978, and word had got around that the time was right for a final push that might just get up politically. It was my first international assignment of many in the four decades that followed. We met with the Minister for Health and his advisors in Port Moresby and shortly after we returned, we received word that the government had agreed to do what we had urged them to do.

The Tobacco Products (Health Control) Act was passed in 1987. I can't recall an easier legislative victory, although word spread in the months and years afterwards that the ban was being barely implemented.

In January 1987, the regional office for the Western Pacific of the World Health Organization in Manila asked me to spend three weeks in PNG and write a 'situation report' on restricting marketing and advancing education about tobacco use. In those days, WHO consultants were required to start and finish any consultancy by flying to Manila, with the field trip sandwiched between the two visits.

In Port Moresby I stayed in a house owned by the Choulai family. Bernard had been a friend in the days I lived in Darlinghurst in the late 1970s. His Chinese-Papuan family had run one of Port Moresby's general stores for decades. He was still in Sydney but assured me I'd be very welcome to grab a bed in the house of his older brother 'Chug' who ran an artefact shop and an adventure rafting business.

He made me feel completely at home and told me to never take a walk out beyond the razor-wired confines of the house's garden because of the very real danger of raskol (pidgin or Tok Pisin for rascal in English) gangs. Port Moresby has long had a reputation as one of the world's cities with the highest violent crime rates.

While I was made welcome in the house, I was not the only one being welcomed. Papua New Guinea has some 1000 traditional indigenous groups, with around 850 different languages being spoken – around a third of the world's total current languages.

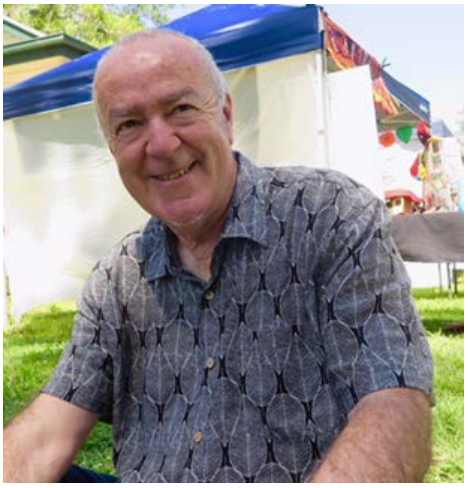
When I arrived back from the WHO office after the first day, someone else had been sleeping in my bed. I spent most of the evening thinking about how I might beat a retreat to a hotel later that night. But when I went back into the room the other person's things had gone, so I stayed put and said nothing.

Chug asked if I might be interested in spending the weekend rafting with about a dozen customers down the Angabanga river. There was a spare space in one of the rubber boats. We'd be leaving the next morning and back in Moresby on Sunday night. A river called the Angabanga sounded like something straight out of a Phantom comic. So the next morning we set off on a three-hour drive from Moresby, at first on a sealed road and then more slowly on dirt.

On a track leading down from a bridge over the river we'd be rafting down, we prepared the boats, put on helmets and life jackets and got brief paddling instructions and what to do if we capsized in the fairly serious rapids we'd encounter within about 100 metres of striking out.

We heard the comforting story about one guy who had capsized and clambered onto a rock platform while still in the rapids and had to stay put on it for 48 hours while the boats made their way downstream, were driven back to the jumping off point and carefully steered to where the man was perched. They said it was touch and go whether a second attempt might have been needed.

The early rapids – as it turned out the only ones – lived up to their threat.



Within minutes of casting off the shore, a woman in my boat had her paddle's handle rammed hard into her chin by the force of the current in the rapids. She split her chin almost to the bone. A doctor who happened to be a passenger in the boat stitched and bandaged it from a first aid kit when we were able to pull in downstream.

Someone offered her a big toke of whiskey they had brought along. We slept the first night in light sleeping bags on a small sandy beach with towering cliffs on either side of us. Fireflies hovered around us and at first light I saw a magnificent large hornbill in a tree near us. Later in the trip we saw small freshwater crocodiles, after earlier being assured there were none in the area we had slept.

On the second day we pulled into a small village where a family had an arrangement with Chug's business to cook up pig meat in a ground oven. In a shallow earth pit, a fire had been heating up rocks before our arrival. Banana leaves were then placed on top of the rocks, and large flaps of raw pig and yams positioned on top of this.

More banana leaves were then added, then soil and more fire started above the soil, if I remember it well enough. We all then sat in a raised, wall-less hut and drank warm South Pacific lager from cans with a few of the men from the household. Betel (areca) nut was offered around.

About four hours after arriving, with us all nearly dropping with hunger and the forgettable effort to politely drink warm, flat beer in the heat of day, steps were taken to check whether the meat was showing

continued on P24

Ridding Papua New Guinea of smoking

continued from P23

signs of being ready. The soil and top layer of banana leaves were removed and after some discussion about whether it needed to stay in for another hour, the vote was to give it a try. With a few exceptions, the slabs of meat were barely warm.

The skin still had bristles all over it, now covered with half congealed, oozing fat making it all the more appetising. I tried to extract what might have been a sliver of lean meat from its thick fat surrounds. The little I got was undercooked, and whatever hunger I had rapidly abated at thoughts of all the stomach problems I could imagine erupting a few hours later.

We took a few tentative bites out of the bland, under-cooked yams and indicated to Bonnie, our crew leader that we thought we'd best continue our journey.

Café food, such as it was in Moresby, was beyond awful in those days. Battered deep fried fish, hamburgers, rudimentary pizza and the very worst sort of Cantonese rice sludge with sweet and sour, black bean or oyster sauce on your choice of meat.

Back in Moresby, I went with another friend to Boroko market and bought a wonderful array of fresh vegetables. Pumpkin leaves and local fish cooked in coconut milk was superb. A stall selling smoked tree kangaroos looked interesting but was too much for us to consume.

You could also buy 'brus' -- thick blackened compressed tobacco leaf, wrapped in newsprint torn from the local Post Courier newspaper. I was told the Post Courier was probably the most smoked newspaper in the world.

My WHO assignment was a matter of gathering what little data on tobacco use, production and taxation revenue available from the government library, talking to a list of government officials someone had prepared for me about the prospects of and barriers to any tobacco control policy getting adopted, and then doing whistle stop visits to Lae, Goroka and Madang to get an away from the capital perspective.

In Lae, the person I was scheduled to see didn't turn up so I walked up one side of the featureless main street and back down the other side. Local youths eyed me suspiciously so I went back to my basic hotel room, read a book and slept until it was time to fly out to Goroka the next day. In Goroka, my hotel was a kilometre or so out of town, down a long driveway from the main road.

I went into town to meet Michael Alpers, the legendary West Australian epidemiologist who had led the genetic research on those from the Fore tribe in the Eastern Highlands who had not died from kuru, the prion disease caused by cannibalism. His group identified a gene that rendered those with it immune to kuru.

Michael was deeply pessimistic about anything happening with tobacco. He told me something that I've used many times since in risk communication lectures about the problems that anyone would face in PNG in trying to convince a typical villager that smoking was harmful.

"They'd take out their packet of cigarettes and ask you to show them which ones the deadly ones so they could throw them away. The understanding of disease causation here only accommodates immediate or very-soon-after causal consequences. You eat bad food or drink bad water, get sick and understand it was just that particular food or water source that was the problem. They have no concept of chronic exposure being a problem down the track."

At Madang, as at Lae, the person I was supposed to see meet was somewhere else, so I again sat on the verandah of my hotel near the sea most of the day, read a book and wandered around.

On my last weekend in Moresby I went to a rugby league match. In a country that had supposedly implemented a tobacco advertising ban several years earlier there was tobacco sports sponsorship advertising everywhere. I went back to Sydney and wrote my report, mailed it to Manila, but refused to go back for the de-briefing ritual.

Smoking rates today in PNG among the poorest communities stand at about 43%.

Child vax figures highest on record – Minister

The vaccination rates for Australian children are at record high levels, with the coverage rate for five-year-olds reaching 94.9 per cent in the year to September 2020, close to the aspirational 95 per cent target. The highest rates of vaccination are among Aboriginal and Torres Strait Islander children at five years, at more than 97 per cent.

The gains were announced by Federal Health Minister Greg Hunt, who said that among all two-year-old children the coverage rate has risen to almost 92.4 per cent, the first time it has climbed above 92 per cent since 2014. He told media on 1 Nov that this augured well for the uptake of a COVID-19 vaccine when one becomes available, probably in the first half of 2021.

The Aboriginal and Torres Strait Islander two-year-old vaccination rate rose to almost 91.2 per cent in the current quarter.

The overall vaccination rate for one-year-olds has also increased in the last twelve months, reaching 94.7 per cent, with Aboriginal and Torres Strait Islander one-year-old vaccination rate increasing to 93.5 per cent.

To achieve herd immunity for infectious diseases, coverage needs to be high. For example, measles is highly infectious and needs a coverage rate of about 92% to 94%.

The picture is less rosy on the NSW North Coast https://www.health.nsw.gov.au/immunisation/Pages/coverage-by-lga.aspx#nnswlhd

The immunisation rate for 5-year-olds across the Northern NSW LHD is 89.9%, dropping to just 73.9% in the Byron Shire, and even lower (63.6%) for 2-year-olds. Richmond Valley LGA tops the table at 95.9% for 5-year-olds, exceeding the

Book Review
by Robin Osborne

Clean

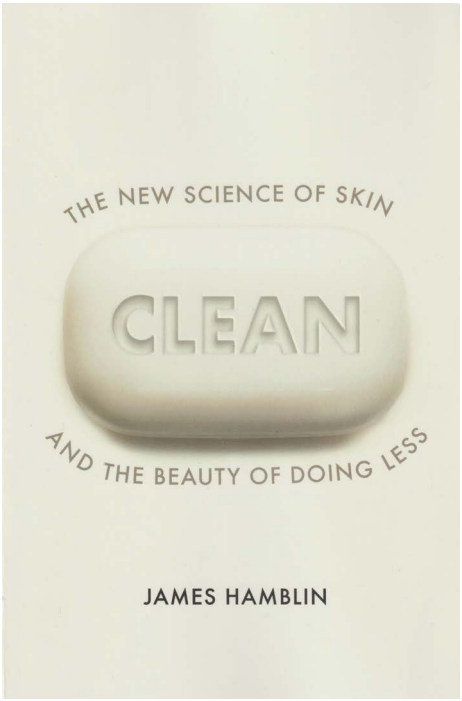
by James Hamblin
The Bodley Head 280pp

Doubtless he will be popularised as the doctor who doesn't wash – just one-part true – but there is much more to this fascinating book, as the sub-title suggests: "The new science of skin and the beauty of doing less."

Let it be noted that Hamblin is not just any doctor but a lecturer at the Yale School of Public Health, a specialist in preventive medicine and a staff writer at The Atlantic. He can certainly write, and to quote someone else who can, the revered Dr Siddhartha Mukherjee (The Emperor of All Maladies, and much more), he has penned an "illuminating and engaging book".

Uncannily, as I was half-way through it, I spotted a full back-cover ad in The Sun-Herald magazine advertising soap: "One bar = up to six bottles of shampoo & conditioner", it was headed, "Try out this new and eco-friendly product today!"

The copy could have come straight from the pages of Clean, whose cover also depicts a bar of soap, and spruiked how the company had saved one million plastic bottles so far, that it is vegan, cruelty free,



eco-sustainable, and a replacement for all hair care products.

Hamblin, who no longer washes his hair, traces hygiene through the ages and charts the history of products with outlandish claims, telling us how soaps such as Palmolive, Dove and Lifebuoy got their names - and markets - and asserting how most of "the myriad products that fill pharmacy shelves today" are not only over-priced and unnecessary but deleterious, whether billed for our health or our beauty.

The bottom line is that skin care products, including soaps, destroy the skin microbiome, which is "a pretty brilliant product of millions of years of evolution... [that] does not need to be maintained in an elaborate way that we didn't already know made our skin look good: sleeping and eating well, minimising anxiety, and spending time in nature."

He argues that the quest for greater cleanliness is not only unsustainable but "may be doing more harm than good," citing how eczema and other topical diseases are more likely to have internal causes, and lamenting our obsession with products from shampoos to moisturisers, probiotics to detox treatments, which all lack proper regulation.

He gives a thumbs-down to dry toilet paper ("You wouldn't come in from gardening and wash your hands with a dry paper towel, so why would dry paper be the standard for cleaning off actual fecal matter?") and douching: "The fallout... may actually be the first widely recognised instance of the negative effects of hygiene on the microbiome."

For the record, the author uses soap after toileting and attends to his private parts. And he has written a terrific book.

aspirational target.

"As we remain focused on COVID-19, it's important that we don't lose sight of the other preventable diseases with which Australian families must contend," Minister Hunt said.

"Our vaccines in the National Immunisation Program are safe, effective and provide a key national response to save and protect young lives.

More information is available on the **Department of Health website.**

Australian Immunisation rates – June 2020 to September 2020		
	June 2020	September 2020
General one-year-old	94.60	94.72
General two-year-old	91.68	92.36
General five-year-old	94.77	94.90
Indigenous one-year-old	93.40	93.46
Indigenous two-year-old	90.03	91.16
Indigenous five-year-old	96.90	97.03

North Coast Radiology Upgrades due to Covid

Like many in the medical industry the radiology sector is navigating uncharted waters due to the increased demand for our services stemming from the Covid19 pandemic.

North Coast Radiology has seen an increase in requests for CT, MRI, Ultrasound and interventional procedures, which has resulted in limited appointment availability and increased hold time when phoning our practices.

To accommodate this increase, North Coast Radiology has applied additional staff resourcing and extended trading hours, which include focused Saturday clinics and late trade days at St Vincent's Hospital and Ballina. The addition of a brand-new CT scanner in Goonellabah has boosted the site to a comprehensive radiology practice offering Ultrasound, CT, Xray, OPG and interventional clinics.

Our team is working tirelessly to accommodate both patients and referrers, whilst maintaining a high level of diligence and we appreciate your understanding and patience.

If you have an exceptional case that requires an urgent appointment, please contact us on our **referrer priority number (02 6625 9310)** to discuss the case with one of our managers.

Accounts for online access to results and images can quickly be generated by contacting our **Client Services Officer (02 6623 6131).**

As always, we will endeavour to provide consistent, caring and professional services to our referring practitioners and patients, utilising advanced state of the art imaging technology.

If you would like to discuss the above, please contact myself or Loretta Brandolini (General Manager) 0418 490 640.

Rachelle Johnston

Client Services Officer

North Coast Radiology Group

02 6623 6131

NSW Health program for new fathers

"Focus on New Fathers" launches in the Northern NSW Local Health District

NSW Health has, for many years, provided parenting support, information and screening that has focused on new mums. Now, we are finding better ways to offer the same kind of support to new dads.

Fathers have an important part to play in a child's life, however one in 20 fathers will experience antenatal depression and one in 10 will experience postnatal depression.

To assist fathers to feel confident and supported in their role, NSW Health is piloting the Focus on New Fathers (FoNF) program.

The FoNF pilot commenced on Father's Day, 6 September 2020, in four LHDs across NSW - Northern NSW, Murrumbidgee, Northern Sydney and Western Sydney. The pilot program is expected to run until 30 June 2021.

To facilitate the pilot, NSW Health has partnered with SMS4Dads at the University of Newcastle. The SMS4Dads service has been operating for a number of years offering information and support to fathers.

The FoNF program is a free and voluntary service available to all non-birthing partners regardless of gender, from all cultural backgrounds. Once a father has enrolled through the webpage (www.health.nsw.gov.au/focus-on-new-fathers), the father will receive regular text messages containing tips, information and links to support them through the process and to assist with understanding how their baby is developing, all from their baby's point of view. The messages focus on father self-care, partner support and father-child attachment. Fathers must be 18 years of age and can sign up from as early as 16 weeks into the pregnancy, up until 24 weeks following the birth of the baby. The messages will continue until the baby is one.

Throughout the process, fathers will also be asked how they are going and linked with further supports if required. If a father indicates distress upon sign up, it will trigger an alert to Perinatal Anxiety and Depression Australia (PANDA). PANDA will then follow up with the father. Fathers are able to opt out at any time by replying STOP to the messages.

In the first week of launching FoNF, 60 dads across the state signed up to the SMS4Dads service, four of which triggered an alert to PANDA from the initial sign up questionnaire. This equates to 15% of enrolments and highlights the significant need for this service.

A previous feasibility study conducted on the SMS4Dads service found that 85% of participants completed the full program, 92% endorsed the program as helping them in their role as fathers, and 81% said it helped the relationship with their partner.

> "I loved everything. The tips, the reminders to stay with it. How to help. Sometimes I felt like you could hear me because the tips always came right on cue."

The Parenting Research Centre has been engaged to conduct a process, outcomes and economic evaluation, in partnership with Deakin Health Economics. The evaluation aims to investigate the effectiveness and sustainability of the FoNF program, as well as to determine if this is an effective and appropriate model for identifying and addressing perinatal anxiety and depression among men and co-parents.

If you come into contact with any eligible fathers, please encourage and assist them to sign up, as this will help us to reach as many fathers as possible, obtain feedback on the service and have ample data to evaluate.

If you would like to experience the service firsthand, there is a professional taster available to help you understand the service and get an insight into the messages that fathers will receive. To sign up for the professional taster, head to www.sms4dads.com and scroll to the bottom left of the screen where you can 'click here for the professional taster'.

For more information or to sign up, please visit **www.health.nsw.gov.au/focus-on-new-fathers.**

Falls Risk in Older Patients

By Alannah Mann

It is estimated that each year in Australia falls occur in 30% of people aged over 65 years living in the community, and 50% of people in residential aged-care facilities(1, 2). In 2018, around 28,000 Australians were hospitalised for hip fracture(3). Complications following hip fractures can be devastating, with 5% of patients dying in hospital, 10% of patients requiring ongoing care in an aged-care facility and more than 50% experiencing a persistent mobility-related disability one year after their fracture(4).

Other adverse outcomes include fear of falling, loss of independence and lower quality of life(2). Many falls can and should be prevented and healthcare workers should be evaluating falls risks regularly (at least annually).

There are multiple factors that may contribute to a person's falls risk (2, 5):

- Alcohol misuse (currently or previously)
- Inappropriate footwear
- Inappropriate eyewear
- Poor lighting
- Pets
- Rugs
- History of previous falls
- Cognitive impairment
- Depression
- Advancing age
- Arthritis
- Dizziness
- Being female
- Incontinence
- Certain medications

Medications are a modifiable risk factor that can be managed. The use of multiple (>5) medications increases the risk of falls, possibly due to an increased risk of adverse events, drug interactions or incorrect use of medicines(2). Additionally, certain types of medications are particularly likely to contribute to falls and fracture risk, including antihypertensives, benzodiazepines, antidepressants, antiepileptic medications, antipsychotics and opioids(2, 6).

Common medication side effects that may increase falls risk include medications that can cause postural hypotension, drowsiness, feeling unsteady, confusion, blurred or double vision and memory problems.

It is important to review all medications regularly and MedsChecks, Home Medicine Reviews and Dosage Administration Aids are all available options to assist with reviewing and managing medications and their side effects.

Strategies that reduce the patient's exposure to medications contributing to falls risk should always be considered. This could include slow withdrawal under prescriber supervision, or using an alternative medication(5).

For example, a common drug interaction that should be avoided is selective serotonin reuptake inhibitors (SSRIs) with benzodiazepines. This combination leads to an increased risk of hip fractures in the elderly (notably, the risk is five-fold when both medications are newly initiated) and falls risks should be assessed before prescribing(7).

Other combinations that increase the risk of fractures in elderly patients include SSRIs with opioids and SSRIs with antipsychotics(7).

Another example would be switching from sedative medications for insomnia to melatonin, which causes less day time sedation. Cognitive behavioural therapy and sleep restriction may also benefit insomnia in older patients(8).

Other approaches to management of falls risk include:

- Incorporating exercise - A 2017 systematic review and meta-analysis found that exercise reduces the rate of falls in community patients by 21%, with greater benefit (rate reductions of 39%) in patients who used programs that challenged balance and exercised more than 3 hours each week(9).

- Employing a multidisciplinary approach - Encourage review of patient by allied health professionals such as occupational therapists (reduce hazards in the home), podiatrists (advise on appropriate footwear or exercises), and optometrists (monitor

for changes to vision and give advice on eye wear).

- Consider vitamin D and calcium supplementation to improve bone mineral density and muscle function. Patients with low vitamin D levels should receive supplementation with at least 1000IU of cholecalciferol per day(8).

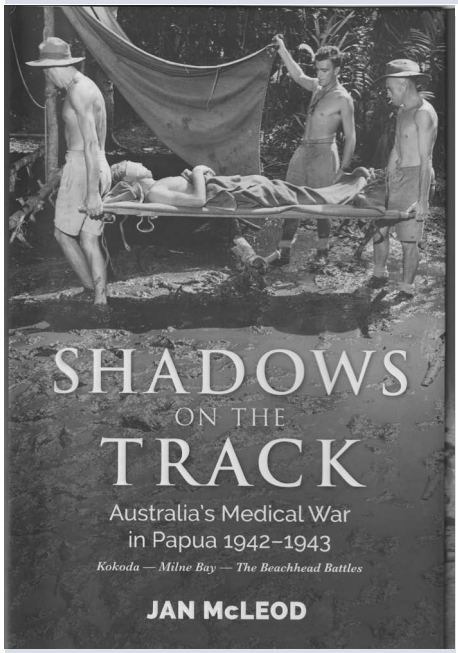
- Encourage the patient to sit and stand up slowly, and ensure adequate hydration(5)

Finally, we should always encourage our older patients to be active participants in their own fall prevention plan that encourages them to stay independent for longer.

References on the **NorDocs website.**

Alannah Mann is a Northern Rivers Pharmacist

Book Reviews



A Medical Emergency

Ian Howie-Willis

Big Sky Publishing 487pp

An Unending War

The Australian Army's struggle against malaria 1885-2015

Ian Howie-Willis

Big Sky Publishing 348pp

Shadows on the Track

Australia's Medical War in Papua 1942-1943

Jan McLeod

Big Sky Publishing 395pp

VD – the Australian Army's experience

Ian Howie-Willis

Big Sky Publishing 430pp

It's said (by Napoleon, supposedly) that an army marches on its stomach, and there's no doubting the strength of a well-fed soldier, but good medical support is arguably as important: a digger struck down by malaria, dysentery or tropical ulcers – to take three of the conditions described in these accounts of Australia's war in the south-west Pacific – is personally hobbled and a drain on resources and morale.

As noted in the preface of the first title, a compendious biography of Major-General 'Ginger' Burston and the Army Medical Service (AMS) in World War II, "Malaria [was] as much the enemy of Australian troops as the Japanese were [it was found the ratio of malaria cases to battlefield casualties was 3.3 to one] ... and remained so throughout the war... the crises were so numerous and of such magnitude that World War II became a long-running emergency for the military medical services."

Given the remarkable story of the GP who went on to become Director General of Medical Services one can only share the surprise expressed by the author of the book's foreword, a distinguished army doctor himself, that this is the first full biography of Dr Burston.

"Burston's leadership of the medical services in those grim years of Australia's greatest military crisis – 1942, 1943 and 1944 – was crucial to the eventual Allied victory over the Japanese. Burston... prevailed upon the allied commanders, Blamey and General Douglas Macarthur, to give primacy to the campaign against malaria, a disease that was quite literally decimating the Allied and enemy forces alike in New Guinea."

Later, amidst criticism of his sycophancy towards Blamey, colleagues conceded that a relationship with Blamey was vital for persuading the latter to prioritise the malaria campaign. According to one senior medico, "He convinced him that if he doesn't deal with malaria he won't have an army to be commander-in-chief of."

During this period the AMS listed 32,000 uniformed personnel, 2500 of them doctors, 3500 nurses, and 900 non-medical officers. This represented some eight per cent of the Army's total strength. As historian Ian Howie-Willis notes, "No Australian head of military medical services before or since has had to manage an organisation so large, diverse and widely dispersed. None has ever borne such huge responsibilities as Burston did during the critical years... when Australians feared imminent Japanese invasion."

Spending 53 of his 72 years in or associated with the Army, with senior post-retirement positions in St John Ambulance and Red Cross, Burston was knighted for his service to the nation, although his role in the PNG campaign was organisational and largely from afar, rather than hands-on.

It is suggested that while others may have had greater clinical expertise, none was a better facilitator and Burston's work in hygiene, dysentery, VD and malaria was peerless. This included "matters as diverse as daily dosages of medication for particular tropical diseases, transport of sick and wounded patients to and from hospital, treatment of hookworm infestations, and inclusion of ascorbic acid, calcium and thiamine tablets in rations."

Nevertheless, Burston drew flack for supporting Gen. Blamey's unfair criticism of troops for a 1942 action in Kokoda, and after the war, miffed for not being suitably decorated, began criticising the Labor government for "obviously doing what it's told to by the Communists and rapidly getting the country into a state of chaos."

It was time for the man whose military career had begun as a bugler in the Victorian militia to step aside. He had been medical protector of Aborigines in the NT, and served in two world wars and many theatres of conflict, from Gallipoli and Flanders to the Middle East, SE Asia and the Pacific. It is indeed surprising that this is the first full-length book on his life.

Not surprisingly, given his role in combatting malaria, Burston figures prominently in Dr Howie-Willis' second title, whose time scale begins in 1885, with the term "unending war" highlighting how the debilitating mosquito-borne disease lives on (it remains endemic in 99 countries). In the Korean War a total of 521 returned soldiers were hospitalised with malaria in Australia, some five per cent of all troops who had served. Yet this made it a

post-war phenomenon, occurring because they had stopped their suppressive doses of paludrine.

While only 1.6 per cent of the 60,000 Australian armed forces personnel in the Vietnam War contracted malaria – two died, and another from agranucytosis associated with the discontinued anti-malarial drug dapsone - "Such statistics are facile... They obscure the intensity and the episodic nature of most of the malaria outbreaks..."

Yet the low mortality rate in Vietnam of only 0.0005 per cent was "not only an achievement but a spectacular victory."

The year 1967 marked the last ADF death from malaria, despite subsequent deployments to malarial zones such as Bougainville, the Solomon Islands and East Timor, with full marks due to the Australian Army Malaria Institute, which by the late 1990s was "well on its way to becoming an organisation for assisting civilian governments around the world as well as the Australian Army at home and in its operational deployments."

Great credit is given to 'Ginger' Burston for his inspiring medical leadership, decades earlier, in the most harrowing of circumstances, although he is less of a hero in Jan McLeod's superb history of the Papuan campaign and, as the sub-title puts it, "Australia's medical war". Again, Blamey is a major player through his directive that all malaria patients and most of the sick and wounded were to be held locally and not evacuated back to Australia for treatment.

"This instruction could not have been issued or enforced without the support of senior medical officers, including... the man ultimately responsible for the Australia Army Medical Service, Maj-Gen Samuel Burston."

At first blush the book's title barely hints at the author's view that preparations to repel the Japanese forces were too little and too late, and that when Australian troops were sent north the medical arrangements to care for them were sorely lacking. The 'Shadows' she writes of fall on the now glorified Kokoda Track campaign and on the Papua deployment more widely.

This is a well-argued and critical analysis of what went wrong, and how the national narrative surrounding Kokoda gilds the reality.

As Dr McLeod notes, the responsibility for Australians' medical care fell to just "a few under-strength and under-resourced field ambulance units. There was no real plan or provision made for the medical care of those initially sent over the Owen Stanley Range to confront the Japanese in July."

By the time 'victory' was declared, around 6000 Australian solders had been killed or wounded, and almost 30,000 had suffered from illness and disease.

Dr McLeod continues, "Viewing the campaign through the lens of Australia's front-line medical units reveals a picture that is markedly different to popular representations which have been inclined to lionise the role of the indigenous Papuan carriers who made a vital contribution to the campaign waged in their country.

"However, the image of 'Fuzzy Wuzzy Angels' bearing wounded Australians to safety has become so ingrained in any representation of the Papuan campaign as to obscure a much more complex – at times inspiring, at times infuriating - reality... Examining the experiences of the Australian field ambulance units calls into question the mythology around the singularly evocative word that has come to represent the entire Papuan campaign - Kokoda."

Adding, "This book challenges that narrative," she presents ample evidence to support her case, contextualising it with our long history of military medical deployments, starting in, of all places, the Sudan, and later in two world wars, and explores Australia's strange governance of the south-eastern portion of the island of New Guinea from the start of the 20th century. Even odder was the control exercised over the northern sector and eastern islands by distant Germany.

Then the Japanese Empire began pushing into the western Pacific, which prompts a damning analysis: "The sluggishness of the implementation and the deficiencies associated with Army administration, the building of fortifications, and the provision of medical facilities suitable for a country at war, suggest a low level of strategic importance had been afforded the military medical services and the Territories of New Guinea and Papua, even at this relatively late stage [in December 1939]".]

A high price would be paid by an Army and a medical corps scrambling to make up for lost time and what would become a tragic loss of lives. This is an important historical work for Australians, and like the other books reviewed is well supported by maps, photographs and extensive footnoting.

According to the prolific Ian Howie-Willis, soldiers also march to the beat of their genitals, and his account of the Army's "experience" of STDs during the 20th century is an uncomfortable one, revealing that more than 125,000 Australian soldiers contracted VD during this time, often while serving overseas.

We learn that gonorrhoea and syphilis "weakened the Army greatly, removing tens of thousands of its troops from service," according to University of Queensland Prof John Pearn who adds in his preface, "VD did not have to occur. Simple precautions in most cases could have prevented it." Yet these were often not practiced, whether in France in WW1 (the high point for acquired infections) or during the Vietnam conflict.

Notably, the more time the men spent in the field flighting, the less they could be in the brothels fornicating. In reference to the South Vietnam bar scene, where one-in-five Australian troops contracted VD, the author notes, "Once again, the inverse relationship between the amount of combat and the rate of VD infection was demonstrated."

The role of prevention measures - advised, if not always followed - and treatments is thoroughly discussed, including the 'No Sweat Pills' to be taken several hours before and after intercourse. Initially planned to be penicillin capsules, they were changed to 100mm capsules of vibramycin (doxycycline) and resulted in the VD rate falling sharply.

Again, the connection between medicine and the military had been proved vital.

Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

Excellence in pathology
Northern Rivers

Sullivan Nicolaides Pathology Lismore

- Comprehensive pathology services provided locally across multiple disciplines
- Extensive esoteric testing available
- Collective expertise of scientists and specialist pathologists
- Supporting and training new generations of medical scientists
- Serving the evolving needs of the region
- 24-hour on-call service at St Vincent's Private Hospital
- Employing more than 100 local staff

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.

SULLIVAN NICOLAIDES PTY LTD • ABN 38 078 202 196
A subsidiary of Sonic Healthcare Limited • ABN 24 004 196 909
24 Hurworth Street • Bowen Hills • Qld 4006 • Australia • Tel (07) 3377 8666 • Fax (07) 3318 7409
PO Box 2014 • Fortitude Valley • Qld 4006 • Australia
www.snp.com.au
Meridio 322441 September 2019

What's your QI?

by North Coast Primary Health Network

In the front line of general practice, Quality Improvement (QI) can be hard to get to. The needs and challenges presented by patient care, service demand, human resources and business viability fill every day to capacity (and that's before you add a global pandemic into the mix).

That's why Healthy North Coast (HNC) launched new online resources in late May via the "Primary Care Impact (PCI)" website, to make it quicker and easier to plan and initiate quality improvement. PCI offers pre-populated quality improvement topics with links to key resources as well as a few basic improvement ideas to get the ball rolling.

It also provides a PDSA (Plan-Do-Study-Act) template embedded with simple strategies to help ensure success. These include canvassing staff on what difference they believe the quality improvement will make, how important it is to them to do it and how confident they are that the team will succeed.

Monika Wheeler, Executive Director Wellness at Healthy North Coast said, "everything that goes into a PCI QI page is designed to quickly get to the core of that particular QI activity and support general practice owners, principles, managers and nurses to move forward easily".

Achieving real change through QI is something to be celebrated and peer sharing is a great way to inspire others to take things on. On PCI, practices can elect to share a PDSA or video about their activity. This becomes easily available to their peers across the footprint, making QI in general practice a social space where practices can be aware of and learn from and encourage one another.

The initial response to PCI has been positive with many practices initially engaging on the COVID-19 pages for **flu vaccination clinics** and **increasing patient and staff safety** (infection control).

Forseeing the challenges for practices delivering flu vaccination to vulnerable groups during the first wave of the pandemic, a pre-launch QI (pilot) page was published directing practices to a set of resources and promoting flu clinic modification as a quality improvement. General practices on the North Coast certainly rose to the challenges posed by COVID-19 and shared many innovative and ingenious modifications to normal practice.

Aggregated data from data sharing practices was used to show vaccination progress over the period from March to June and Healthwise and Durri Aboriginal Medical Service shared videos on how they tackled vaccination during COVID-19.

Since then **Central Pottsville Medical Centre has shared their PDSA for increasing vaccination to vulnerable groups**. These PDSAs have been picked up by the National Centre for Immunisation Research and Surveillance (NCIRS) who ran a newsletter article to their readership about Central Pottsville Medical Centre's QI and invited HNC and the practice to be part of a national PHN showcase on improving immunisation rates next year.

Five months on, 69 practices across the region have engaged with PCI including 13 who have shared PDSAs either with everyone or with HNC. The PDSAs are a great tool for learning and growth and everyone in general practice is encouraged, no matter how complex or humble, to share their PDSA.

"The positive reaction from practices and our own Primary Health Coordinator staff has surpassed our expectations and we are looking to improve and develop PCI further" said Monika Wheeler.

The introduction of the PIP QI incentive payment in August 2019 has also been at the forefront of thinking in PCI and the **topics page** includes templated activity pages with resources and ideas for each of the ten PIP QI measures. QI activities on the topics page are coded orange or green to denote the level of involvement required to complete them. PIP QI activities focusing on recording key health data and other activities that are less involved or intrusive to the practice as a whole are coded orange.

In addition to orange level activities, PCI also includes more complex QI activities around recalls and reminders and health coaching – these are coded green to denote the fact that they will involve more staff and require more time and change to current practice. HNC has contracted Medicoach to provide personalised practical in-practice facilitation for practices working on green level activities to help principals and managers get on top of more involved activities more easily and get the team working towards their QI goals. HNC's **Primary Health Coordinators** and **Aboriginal Health Coordinators** are also available to assist practices and Aboriginal

continued on P34

What's your QI?

continued from P33

Medical Services achieve their QI goals.

To date more than 23 practices have requested in-practice assistance from Medicoach with nine others in the enquiry phase. While Medicoach has been able to provide practical assistance to develop whole-of-practice chronic disease management and care planning systems, many practices have also requested and been provided with team-building and communication workshops to re-energise and focus teams weary from dealing with the constant threat of COVID-19. The feedback on personalised in-practice facilitation has been very positive:

"Thank you so much, that's made such a difference already. I haven't seen them that motivated... ever. I have been trying to implement chronic disease systems for three years," said one Practice Manager and "thank you for this educational opportunity and the motivation to move forward in quality improvement" said another.

Data sharing practices have received and signed their data sharing agreement with HNC over August and September 2020. These agreements detail what data is shared and how it is stored and used. Practices upload their data once each quarter to meet their obligations under the PIP QI program and currently, quarterly reports are delivered to general practice summarising individual practice progress on the PIP QI ten measures alongside aggregated progress data for the whole of the footprint. HNC looks forward to further integrating activity on PCI with shared data in order to help practices see their quality improvements come to life.

You can talk with your **Primary Care Coordinator or Aboriginal Health Coordinator** and visit **Primary Care Impact on the HNC website** for more information.

NorDocs

Monthly Webinars

Next webinar in February 2021

CPD points for Professional Development

info@nordocs.org.au
nordocs.org.au
follow us on Facebook

No silver bullet when treating shoulder injuries

by Helen Willoughby

Many Australians will experience a shoulder injury, the most common being an impingement, rotator cuff tear or some form of scapula instability. Sometimes shoulders become 'frozen', a highly debilitating condition requiring intensive treatment.

According to Dr Shane Brun, who published research on managing shoulder injuries in the April 2012 edition of Australian Family Physician, 50 percent of people will recover from shoulder injury within a month with early intervention, while more acute conditions can take up to 12 months, or even longer, for the shoulder restrictions to ease.

The causes of shoulder injury are numerous but there is broad agreement among researchers that with the more acute conditions the prevalence of long-term, repetitive movement is a contributing factor. However, it is too easy to pass a shoulder injury off as 'wear and tear', as I have discovered in my own long journey towards recovery.

Following is a three-month account from the moment I decided to take my shoulder injury seriously.

Late August 2020

Earlier this year my right shoulder developed what I suspected to be a rotator cuff injury (which I've had before but largely ignored). Basic movements, such as weeding the garden or even reaching up to a cupboard are producing a burning sensation in the tendon at the front of the shoulder. I've lost range in the lateral lift of my right arm and the condition is starting to interfere with my sleep. Even typing without support under my forearm is causing pain to my shoulder.

I'm Googling furiously, trying ice packs, anti-inflammatories, massage and acupuncture. Frustratingly my research is throwing up contradictory evidence and I remind myself that Dr Google is often not reliable.

Niggling shoulder issues have been there for as long as I can remember but it wasn't until I started practicing yoga in my late thirties that I found them a restriction. Before then my main exercise had been

running and cycling and throwing myself hard into just about everything I did – work, family life, social life, a farm. I treated my body as a tool to get things done, rather than with care.

This time around the body isn't bouncing back and I finally bite the bullet. As a relatively new resident of the Northern Rivers I need to find a GP, and I am referred for x-rays and an ultrasound.

31 August

It is my first visit to North Coast Radiology for my shoulder x-ray and ultrasound. All goes smoothly and I now know I have bursitis and some tears in my rotator cuff – exactly where I'm not sure. I have been desperately hoping for no tears as they sound difficult to heal. The bursitis I think should be easily fixed with some anti-inflammatories. What will be harder will be to rest as recommended. Resting is not one of my strong suits.

1 September

Back at my GP who explains that tears are more prominent in people my age (over 50 years) and refers me back to North Coast Radiology for what will be my first ever cortisone injection. I am in two minds about the injection as I've heard plenty of stories about them not working. Because the inflammation is causing so much discomfort, I accept the recommendation.

I've pulled back on some activities – including modifying my yoga practice and stopping heavy gardening work.

8 September

Back at North Coast Radiology and again all goes well. I am surprised at the brevity and ease of the cortisone treatment. The doctor who administers the injection is incredibly thorough in her explanations, advising that every individual responds differently to the treatment.

I am quickly disabused of my belief that the cortisone will kick in immediately and I will be free of pain within a day or two. As explained, cortisone takes days, often weeks, to take effect as the hormones are slowly released into the affected area. For some people the first injection may not result in any significant improvement.

As I am about to find out, I am sadly in that camp.

Late September

The only change I can feel from the cortisone injection is the tendon at the front of my right shoulder is not as sore to touch. It feels like the inflammation is reducing but it may be my imagination. I know the shoulder and arm are still very weak and some days it seems they are further deteriorating.

The only upside is I am learning a great deal more about injury management. My daily yoga practice remains an important ritual to keep the shoulder moving.

Early October

I decide not to have a second cortisone injection but rather to try alternative treatments, including more massage and acupuncture. I also return to a relatively normal yoga practice, while still avoiding moves that irritate the injured area. Mostly these bring relief but surprisingly I find my condition worsens after some treatments.

Nerve pain has shifted further down my bicep and sometimes the whole right arm aches down to the wrist. I'm most definitely not resting enough.

Late October

My yoga practice continues to provide

continued on P36

No silver bullet when treating shoulder injuries

continued from P35

relief. It's also helping with patience as I learn to listen to my body. I accept now there is no silver bullet and that I can't expect after decades of constant activity for my body to recover as easily as it once did.

It sounds counterintuitive for someone who practices yoga regularly to have to be reminded to let the body restore. But we yogis are at times our own worst enemies!

Mid November

I am recommended a chiropractor to determine if something more is going on that is preventing the shoulder from healing. It is early days and things are looking promising, particularly the focus on strength building for the scapula. Intuitively this makes sense and even after a week of specific exercises I am noticing some change.

I accept less reluctantly that I am in this for the long haul and will benefit from the experience. I have come to appreciate that for a yoga teacher, or anyone working with human bodies, injuries are "blessings in disguise". Not only do you develop empathy, you become more sensitive to what aggravates and what aids in their treatment. As for the cortisone treatment – the jury is still out.

Post-script

Even before my shoulder treatment commenced, I had a rudimentary understanding of the anatomy of the shoulder, and its dynamic movements. I knew from yoga training and my own injury that there were ways of managing shoulder injuries to provide some relief but more importantly to not irritate and further inflame.

What I didn't appreciate at the beginning of this ongoing journey is that the next few months would deliver a much deeper understanding of the shoulder mechanics and about how treatment cannot start or end with the injury itself. Our habits, our activities, even our mindset all play a role.

When my rotator cuff first presented itself as a nagging, burning sensation across the tendons at the front of my right deltoid I thought I could beat it with a day or two's rest. I tried anti-inflammatories, some ice and a more gentle yoga practice. I often fooled myself that it felt better until finally I had to admit this was no passing ailment. I needed treatment. But first I needed to know what was going on.

Most importantly, I have learned to exercise more patience and to trust the healing process, which will take all the time it needs.

Helen Willoughby is a certified Iyengar yoga instructor and long-time practitioner.

Royal Commission highlights disability horror show

The opening words were ominous but sadly predictable... “We have heard about the violence, abuse, neglect and exploitation experienced by people with disability in many different systems including education, homes and living arrangements, health, the justice system and the NDIS...”

The interim report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability was written under “circumstances that were not, and could not have been, anticipated when the Royal Commission was established in April 2019,” wrote the Chair, The Hon Ronald Sackville AO QC.

The reference was to the COVID-19 pandemic, which “has affected, in one way or another, every person in this country.”

Justice Sackville added, “With the exception of people in aged care facilities [the subject of **a separate Royal Commission** whose interim report was tabled in October 2019] no group has been more profoundly affected than people with disability.”

The 550-page document makes gruelling reading, drawing on over a year’s worth of testimony and submissions from people with disability and their families and supporters, as well as many organisations, the Commission’s First Nations Peoples Strategic Advisory Group and a range of other experts.

From the outset the Commissioners take pains to define violence and abuse, which “include assault, sexual assault, constraints, restrictive practices (physical, mechanical and chemical), forced treatments, forced interventions, humiliation and harassment, financial and economic abuse and significant violations of privacy and dignity on a systemic or individual basis.”

Then there is neglect –

which includes physical and emotional neglect, passive neglect and wilful deprivation. Neglect can be a single significant incident or a systemic issue that involves depriving a person with disability of the basic necessities of life such as food, drink, shelter, access, mobility, clothing, education, medical care and treatment.

And exploitation –

the improper use of another person or the improper use of or withholding of another person’s assets, labour, employment or resources, including taking physical, sexual, financial or economic advantage.

While specific recommendations await the release of the final report due by 29 April 2022, the Commission identified a number of themes that it said “cut across many or all areas of a person’s life and the systems they use and rely on.”

These themes include: • choice and control • attitudes towards disability • segregation and exclusion • restrictive practices • access to services and supports • advocacy and representation • oversight and complaints • data • funding.

The interim report, like the Aged Care Royal Commission’s, shows that the right minds can clearly identify the challenges and shortcomings – and, if the truth be told, the abuses – of a complex service environment involving governments, the private sector and not-for-profit providers. The anonymised case histories add further weight to their observations.

More challenges lie ahead, shown by a delivery time for the final report that surpasses the period taken up by hearings, the receiving of submissions and related research.

Then will come the response of the Federal Government, which, as the authority that called the Royal Commission shortly before the 2019 election, will ‘own’ the recommendations.

Choking back tears when he announced the inquiry, PM Scott Morrison said

Justice Sackville’s team would look “both backwards and forwards” as well as investigating the much-criticised National Disability Insurance Scheme.

An emotional Mr Morrison quoted his brother-in-law Gary, who has multiple sclerosis, as saying, “It is not flash being disabled, but the good thing is that that’s the condition you live with in Australia and that you’re an Australian.”

From the evidence so far it seems that being disabled in Australia may not be so flash either.

Greens Senator Jordon Steele-John, a leading advocate for the Commission and a person with disability, told ABC News, “We are dying in our homes, in our workplaces, in our educational spaces. We are being raped, we are being starved, we are being beaten.”

Senator Steele-John felt disappointed there was no mention of redress in the terms of reference. As another Royal Commission, the one into Institutional Responses to Child Sexual Abuse, showed, this could really have opened up a can of worms.

- Robin Osborne

UCRH team wins $1M grant

A team of researchers from the Lismore-headquartered University Centre for Rural Health (UCRH has been awarded a grant of $1,035,000 by the National Health and Medical Research Council (NHMRC) to help improve support to pregnant women to quit smoking.

The team, led by Associate Professor Megan Passey (photo above), is collaborating with a broad coalition of health bodies, including the Northern NSW Local Health District, four other Local Health Districts, the NSW Ministry of Health, the Cancer Institute NSW, the NSW Cancer Council and colleagues from the University of Newcastle.

Smoking is the single most important preventable cause of adverse pregnancy outcomes, including stillbirth, preterm birth and low birth weight. These harms are reduced if women stop smoking during pregnancy.

Many pregnant women are motivated to quit but face significant challenges including a lack of effective support from health professionals. The project will trial an innovative, evidence-based program – **MOHMQuit** (Midwives and Obstetricians Helping Mothers to Quit).

MOHMQuit is a multi-component program designed to help managers and clinicians to better support pregnant smokers to quit.

It takes a whole-of-system approach and includes system-, manager- and clinician-focused elements and was developed collaboratively with project partners. The project will implement MOHMQuit in eight public hospitals providing antenatal care across NSW and test whether it is successful in helping mothers to quit.

MOHMQuit

Midwives and Obstetricians
Helping Mothers to Quit Smoking

Dr Passey said, "This is a wonderful opportunity for our region and for pregnant women and families across NSW, as we'll now be able to help reduce the harms from smoking.

"This builds on six years of work we've been doing with Clinical Midwifery Consultant, Cathy Adams, and others at the Northern NSW LHD, and it's great to see this partnership enter another phase."

The breakout that never was

How times change. At the end of October, while in Tokyo for official meetings, the Australian defence minister Sen. Linda Reynolds presented her counterpart, a keen fisherman, with an Akubra hat. He was delighted and promised it would be his new fishing hat.

On 5 August 1944 the only Akubras in evidence around the POW camp in Cowra sat on the heads of the Australian guards charged with overseeing 1104 Japanese captives, mostly taken in the Pacific and PNG, Italians captured in north Africa and pro-republican Indonesians sent to Australia by the Dutch as Japan moved into the Netherlands Indies.

While some of the Italians were fascists, most were not and these were allowed to work on local farms where they caused no trouble. Similarly, the Indonesians adapted peacefully to camp life, albeit far from home.

The Japanese, however, had been indoctrinated into the Bushido warrior code and regarded capture as the ultimate humiliation. Death, through any means, was seen as preferable to imprisonment.

"The Japanese do not have a word for 'honourable prisoners of war'," said the subject of Graham Apthorpe's account The Man Inside, a profile of a Japanese officer whose defiance helped fuel the uprising but who was detained in a Sydney mental hospital at the time it occurred.

"Therefore, the only thing left for me is the choice of when to die."

Although treated far better than Australian POWs in Japan's southeast Asian camps, the Japanese were aggrieved by a cut to their cigarette ration and a plan to split off half their number to another camp. Armed with baseball bats, mess cutlery and anything that might serve as weapons, they acted in accordance with a prearranged plan and stormed the inadequate fences, rushing into a hail of bullets from Vickers and Bren guns, scrambling over piles of their dead to bash and kill the few Australians they could get their hands on.

Some escapees absconded into the surrounding countryside, often suiciding through ghastly means such as lying on railway tracks.

Survivors would later insist the infamous "Cowra breakout" was a mass suicide action rather than an escape attempt, for the prisoners knew they had no hope of getting back to Japan where in any case they would face court-martial, probably execution, and disgrace in the eyes of their families.

Indeed, many returnees did not reveal having been POWs for years, until a Cowra veterans' group was formed and they and other Japanese began visiting Cowra as a kind of pilgrimage.

By that time a reconciliation process was well under way, focused on the construction of a 12.5 acre Japanese peace garden designed by a world renowned landscape architect, Ken Nakajima. He called it the best in the world outside the Imperial Palace in Tokyo.

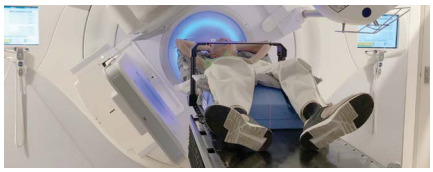
The garden opened in 1979, with stage two completed in 1986. It comprises 124 botanical species, predominantly Australia natives, many topiarised in Japanese style, running water, dramatic rock scapes, Koi carp and wild ducks. Attached is a cultural centre with a superb collection of Japanese art and handicrafts.

The fame of the 'breakout', brutal and mismanaged as it was on both sides, is well surpassed by an attraction that is increasingly popular with visitors from around the world. Australians on a road trip should not pass it by.

GenesisCare

Treating the most frequent malignancies in Australia: non-melanoma skin cancer and radiation therapy

Australia is the unfortunate world leader in both melanoma and non-melanoma skin cancer (NMSC)[2]. NMSC is comprised of several subtypes with the two most frequently occurring being squamous cell carcinoma (SCC) and basal cell carcinoma (BCC). NMSC is not only cause for concern due to its high prevalence in Australia, but also because of its association with increased morbidity, mortality, and negative impact on quality of life[2,3]. Each year, NMSC is responsible for 95,000 hospital admissions, the highest for any cancer in Australia, and 500 deaths[3].



Patient being treated with VMAT[1]

Current treatment options for NMSC

The treatment modality employed for NMSC depends on several factors including tumour type, stage, size, location, and patient specific characteristics[4]. Current treatment options include topical chemotherapy (5-fluorouracil), immunotherapy (imiquimod), electrodessication and curettage, cryoablation, photodynamic therapy, surgery (gross excision or Mohs) and radiotherapy[5]. Surgical excision is the most frequently employed treatment for BCCs and SCCs, however, this approach is not always an appropriate option, particularly for patients with skin field cancerisation (SFC), a condition defined by a histologically abnormal field of lesions that extends beyond 50cm[2] [6-8].

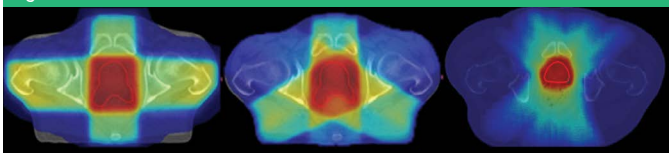
The evolution of modern radiation therapy

Advances in radiation therapy techniques have revolutionised cancer treatment and have led to improved safety, efficacy and patient outcomes[9]. Since the introduction of conventional radiation therapy in the 1960's, there has been a consistent effort put towards improving the precision of radiation therapy to ensure maximum dose is delivered to the target cancer tissue while lessening the impact on healthy tissue[10]. These advances have led to the development of 3D conformal radiation therapy (3D-CRT), intensity modulated radiation therapy (IMRT), and the most recent advancement, volumetric modulated arc therapy (VMAT). A brief summary of these radiation therapy modalities can be found in Figure 1.

Treating NMSC with radiation therapy

Radiation therapy has been shown to be efficacious in treating NMSC[5-7]. The treatment of NMSC with radiation therapy is accomplished through two mechanisms, first through directly inducing DNA damage in target cancer cells and second through indirectly damaging cancer cell DNA via the production of free radicals[11, 12]. The use of radiation therapy for treating NMSC is gaining momentum, particularly for patients with recurrent lesions, those who have not responded to conventional therapies, or those who have extensive SFC where surgical excision is not warranted[4-6]. radiation therapy is also useful when combined with other treatments, particularly as an adjuvant to surgery which works by destroying cancer cells that may have been left behind during surgery[11-13]. The addition of radiation therapy to a treatment regimen lowers the risk of cancer recurrence and helps treat skin cancer that has metastasised[11-13]. Before and after Radiation therapy treatment photographs of a patient treated at GenesisCare can be found in Figure 2 and a summary of results from our ongoing clinical registry are below.

Figure 1. 3D-CRT IMRT VMAT



3D-CRT uses computed tomography to create a 3D conformal dose of radiation. Beams are shaped around tumour contours with a collimator which blocks rays to healthy tissues. Tumours are irradiated using four opposing fields resulting in a high-dose zone where the beams overlap.

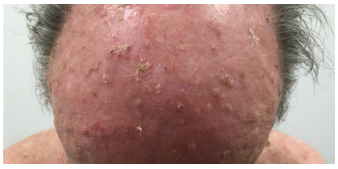
IMRT allows the radiation dose to conform more precisely to the 3D shape of tumours by changing the radiation beam into multiple smaller beams which allows the tumour to be targeted from several angles. Mobile computer-controlled collimators create additional degrees of freedom that help shape the high dose region around the target.

VMAT is an advanced form of IMRT that delivers a continuous radiation therapy dose in an arc-shaped pattern that moves around the tumour and changes shape and dosage accordingly. Due to its accuracy, VMAT can be used when tumours are in close proximity to critical organs. This also allows treatment to be delivered faster with a total treatment time of 10–15 minutes.

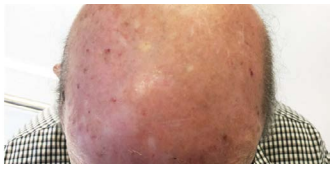
[14]Images adapted from Vanneste et al. 2016.
Note: these images are used for the purposes of showing the general beam pattern and dose distribution of each radiation therapy modality and are not representative of the dose distribution when treating skin.

Figure 2. Patient with widespread NMSC of the scalp before and 12 months after VMAT treatment.

Before



After



Outcomes 24 months after radiation therapy treatment[15]

85% of treatment areas received a cosmetic score of good or excellent*

83% of patients had undergone previous treatment with other therapies

80% of treatment areas had complete clinical clearance of non-melanoma skin cancers

*Cosmetic scores assessed using Lovett et al (1990) scoring tool[16]

Should you wish to discuss the management of your patients with a radiation oncologist, or for further information, please contact:

Rebecca Kavanagh or Christopher Bartley **Tel:** 1300 422 753 **Email:** OncologyQLD@genesiscare.com

References:
1. Elekta website. Retrieved on 24 July 2020 from https://www.elekta.com/radiotherapy/treatment-solutions/quality-assurance/elekta-vmat/. **2.** Bray F et al. Global Cancer Statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin (in press). Retrieved on 26 July 2020 from http://gco.iarc.fr/. **3.** Australian Institute for Health and Welfare, Australasian Association of Cancer Registries. Cancer in Australia: an overview 2012 (AIHW Cat. No. CAN 70; Cancer Series No. 74). Canberra: AIHW, 2012. **4.** Fahradyan A et al. Updates on the Management of Non-Melanoma Skin Cancer (NMSC). Healthcare (Basel). 2017;5(4):82. **5.** Foley P et al. Cancer Council Australia Keratinocyte Cancers Guideline Working Party. Sydney: Cancer Council Australia. Retrieved on 26 July 2020 from https://wiki.cancer.org.au/australia/Guidelines:Keratinocyte_carcinoma/Other_treatments_(topical_agents). **6.** Fogarty GB et al. Can Modern Radiotherapy be used for Extensive Skin Field Cancerisation: An Update on Current Treatment Options. Biomed J Sci &Tech Res 4(1)- 2018. BJSTR.MS.ID.000998. **7.** Non-melanoma Skin Cancer Working Group. The 2002 national non-melanoma skin cancer survey. Carlton, VIC: National Cancer Control Initiative. Retrieved on 26 July 2020 from: https://canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/national-cancer-control-initiative-1997-2002-report. **8.** Kanjilal S et al. Cancer Res 1995;(55) (16):3604–9. **9.** Garibaldi C et al. Recent advances in radiation oncology. Ecancermedicalscience. 2017;11:785. **10.** Chen HHW and Kuo MT. Improving radiotherapy in cancer treatment: Promises and challenges. Oncotarget. 2017;8(37):62742–58. **11.** Little JB. Principal Cellular and Tissue Effects of Radiation. In: Kufe DW, Pollock RE, Weichselbaum RR, et al., editors. Holland-Frei Cancer Medicine. 6th edition. Hamilton (ON): BC Decker; 2003. Available from: https://www.ncbi.nlm.nih.gov/books/NBK12344/. **12.** Baskar R et al. Biological response of cancer cells to radiation treatment. Front Mol Biosci. 2014;1:24. **13.** Veness MJ et al. Current Role of Radiotherapy in Non-melanoma Skin Cancer. Clinical Oncology, 2019;31(11):749–58. **14.** Vanneste BGL et al. Prostate Cancer Radiation Therapy: What Do Clinicians Have to Know?. Biomed Res Int; 2016:6829875. **15.** GenesisCare unpublished data on file **16.** 16. Lovett RD et al. Int J Radiat Oncol Biol Phys. 1990 Aug;19(2):235–42.

SCU grad wins Brett Whiteley art scholarship

Southern Cross University Fine Arts graduate Emily Imeson is part of an small group of young Australian artists named as joint winners of the prestigious 2020 **Brett Whiteley Travelling Artists Scholarship.**

Their individual prizes included $10,000 and a two-week residency at Kangaroo Valley in the NSW Southern Highlands where they were mentored by some of Australia's leading artists, including Ben Quilty, himself a former Brett Whiteley scholarship winner.

"Being a recipient of the Brett Whiteley Travelling Artists Scholarship 2020 is a great complement to my emerging practice," Emily said.

"Not only will it provide opportunities to develop and evolve as an artist, the support and encouragement is unparalleled. It is hard to express my gratitude, I have been working towards this goal for many years.

"The artists associated with this award have been a great inspiration, as the art of Brett Whiteley will always be. I am grateful to be recognised as a worthy scholar. Thank you, Lucy Culliton, Wendy Whiteley, the Art Gallery of NSW, and the Brett Whiteley Studio."

Emily Imeson's *en plein air* (outdoors) painting style has helped her win a prestigious Brett Whiteley Travelling Artists Scholarship. Here she is hard at work at Naughton's Gap, near Casino.

Normally the prestigious scholarship goes to one young Australian artist to further their art education in Europe but with borders closed by COVID-19 the judges were forced to adapt the 2020 program. The annual art prize was established by Whiteley's mother Beryl in 1999, in memory of her famous son.

Emily said she spent the past two years living "a nomadic lifestyle", drawing inspiration from each state and territory, learning and exploring diverse landscapes, and using the outdoors as her studio.

While camping in Southern NSW in November she was finalising her next solo show 'Ancient River, River Red' at Saint Cloche Gallery in Sydney's Paddington, set for January 2021.

Emily grew up in Tamworth and Lismore, and believes that the surrounding environment has helped her develop a great appreciation for the Australian land and the life it sustains.

Emily's work features in the Macquarie Group Collection after the corporate bank acquired her painting "Alive in the dead of night" as part of its 2019 Macquarie Group Emerging Artist Prize.

Soon after graduating from Southern Cross University in 2016, she was recognised by Create NSW with a Young Regional Artists Scholarship.

Dr Wes Hill, course coordinator of the Bachelor of Art and Design, said Emily's success was a wonderful achievement.

"It's testament to Emily's hard work and commitment to her practice, as well as to the outstanding quality of teaching here at Southern Cross University. Her lecturers, including myself, are very proud."

Carers coping worse than clients under the NDIS

While the performance of the National Disability Insurance Scheme has usually been assessed on the welfare of participants, a study by Southern Cross University has shown that carers face a range of previously unidentified challenges, some of them deleterious to their mental health.

The 18-month study, ***Understanding the Impact of the NDIS on Regional Carers A Multi-method Study | June 2020***, surveyed 70 carers from the Mid North Coast and asked about their experience caring for a person with a disability after becoming part of the NDIS.

"One of the main findings was the need to improve the wellbeing of carers and to ease the significant administrative burdens many face when dealing with the complex NDIS system," according to SCU's Professor of Mental Health John Hurley who identified a blend of both positive and challenging outcomes for carers.

"Carers reported physical and psychosocial improvements for NDIS participants," he said.

"But it's concerning that there still exists a higher than average risk for depression, demonstrating that carers still face wellbeing challenges. As a result, there's a need to increase the training, qualifications and capabilities."

However, there are not enough services in regional NSW to fully meet the needs of the NDIS participants, he added.

Key recommendations in response to the findings aim to reduce carer stress and the time spent on administrative burden.

"Enhancing carers' experiences of the NDIS workforce and planning process are other aims of the recommendations. Where time spent caring can be reduced there is increased opportunity for carers to focus on their needs and the needs of others in their social system," the report said.

"Individualised wellness and recovery action plans can be developed to support more frequent self-care strategies. The minimal changes to carer wellbeing outcomes in this study suggest additional research is required to formulate effective wellness strategies going forward."

The report was partly funded by NSW Department of Communities and Justice and has been submitted to the National Disabilities Agency for further consideration.

Link to ***(PDF) Understanding the Impact of the NDIS on Regional Carers.***

Bridging the health divide

THE UNIVERSITY OF WOLLONGONG IS COMMITTED TO IMPROVING THE HEALTH AND WELLBEING OF PEOPLE LIVING IN RURAL, REGIONAL AND REMOTE AREAS AND HAS BECOME A LEADER IN THIS SPACE.

People living in rural, regional and remote Australia typically don't enjoy the same high standard of health and wellbeing as those who live in the cities, or the same access to health services and health related infrastructure.

The University of Wollongong has demonstrated this commitment from the training of doctors and nurses with placement programs in regional and rural settings to world-class research and Australia-first programs targeting Indigenous health, early childhood, ageing, dementia and mental health.

The University of Wollongong believes that an important part of improving rural and regional health is to ensure that the people affected most – communities, patients and their families – are included in the process. That's why we partner with an extensive network of communities and health providers right across NSW and across a range of settings and disciplines including general practices, hospitals, allied, community and Aboriginal health services.

UNIVERSITY OF WOLLONGONG AUSTRALIA

UOW.EDU.AU #THISISUOW

Making space – building our story.

Staff and student community day with artist Emma Walke and UOW facilitator Rebekah Hermann

Under the inspiration of Emma Walke and the Caucus Not Caucus committee of the UCRH, medical students from UOW, WSU and USYD, along with UCRH staff and community members participated in "Making Space- Building our Story"- two aboriginal culture learning and development days to make the items needed for a reflection/ bush tucker garden. Local aboriginal community members shared their knowledge of clapstick making, plants and pottery, with enthusiastic students producing their own sets of clap sticks and their own ceramic tiles. The tiles were individual's contribution to 'building our story' and would later be added to the garden, part of an ever changing and growing river that will 'build our story' of the UCRH over time.

Day two of the workshops saw students planting the reflection/ bush tucker garden with edible and medicinal plants – the benefits and purpose of which were discussed by the aboriginal knowledge holders.

The workshops would not have been complete without a huge feast lovingly prepared by community members which included kangaroo, bugs, prawns, fish and salads. Huge thanks to the DVC-ISS – "Unfinished Business"- grants project, that has provided the CNC with the funds to make these valuable Aboriginal immersion activities and the reflection space possible.

Indigenous community day @ UCRH - Phase 3 students Justin and Holly working on their clap sticks.

Indigenous community day @ UCRH - Ann burning designs into clap sticks, Bek making a clay tile for the native indigenous plant garden

Indigenous community day @ UCRH - Indigenous health academic lead Emma Walke demonstrating tile making.

Indigenous community day @ UCRH - Some of the tiles made prior to baking.

Dr Adem Can

Dr Gary Persley

Dr James Whan

Dr Basem Dall

Dr Vicky Satchwell

THE TEAM AT
CURRUMBIN CLINIC

THANK YOU FOR YOUR SUPPORT IN 2020 AND WISH YOU AND YOUR FAMILY A SAFE AND HAPPY CHRISTMAS!

Dr James Goldstein

Dr Brook Burchgart

Dr Matt McDornan

Dr Chris Danesi

Kate Cross
Currumbin Clinic CEO

Catherine Fitzsimmons
Business Development and Relationships Manager

Dr Tim MacDonald

We look forward to providing you and your patients exceptional mental health care and support during the holidays and into 2021

MENTAL HEALTH AND ADDICTIONS
Admissions and Assessment
1800 119 118

Currumbin Clinic

ACCEPTING PRIVATE MENTAL HEALTH ADMISSIONS OVER THE CHRISTMAS AND NEW YEAR PERIOD

37 Bilinga Street, Currumbin QLD 4223
T: 07 5534 4944 F: 07 5534 7752
E: currumbinclinic@healthecare.com.au / **currumbinclinic.com.au**

healthe.care™

Luye Medical