NorDocs

The quarterly magazine of the Northern Rivers Doctors Network

Spring 2020







Masks now matter - COVID-19 continues

Mega jail opens

SCU active in health space

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The quarterly magazine of the Northern River Doctors Network

Published by:
Northern Rivers Medical Network
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IN THIS ISSUE

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ON THE COVER:

The anti COVID-19 warriors on our cover represent a broad cross section of Australians taking medical advice to wear protective masks in public places. As the Department of Health advises, "Wearing a mask can help protect you and those around you if you are in an area with community transmission, and physical distancing is not possible." **Detailed information** on the design and wearing of masks is available at the DoH Covid-19 health advice web page.

We thank those who contributed photos to help make the important point that masks are a key part of the armoury, along with hand sanitising, social distancing and other recommended health measures.

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Editorial: COVID-19 continues to dominate our lives

After the initial wave and restrictions, life for many North Coast residents returned to some degree of normality. Others lost their jobs, possibly forever, although the full economic impact of this was mitigated to some extent by the Federal government's emergency financial packages. As time passed and the numbers decreased, restrictions eased and retail and restaurants gradually reopened for business. There seemed to be light at the end of the tunnel.

Some businesses boomed through the crisis. It was a great time to be in the home renovation, surgical supply or cleaning businesses, with orders coming in thick and fast.

Then the second wave hit Victoria. While not totally unexpected it was literally a shock to the system. We became used to seeing Premier Dan Andrews trudge out in front of the TV cameras for the daily briefing to disclose the latest number of cases and deaths. The relentless rise weighed heavily on everybody's mind and for some it brought back **memories of the nightly television reports** from the late 60s and 70s of the daily body count during the Vietnam war.

The infection spread like the bush fires of summer 2019. There were spot fires in a few suburbs, then a city and finally a state was in full lockdown. There was fear of contagion to other parts of the country and the walls went up on the State borders.

Once again everybody was tense. The bipartisan effort along with similar commitments from industry and government began unravelling. It became State against State against Commonwealth, business against public health and person against person. There was increasing anger directed to the perceived perpetrators of **Lotharian guards**, **bogan Logans** and **covid Karens**. The "We're all in this together" resolution was falling apart.

At the time of writing in late August, NSW, Queensland and other States appear to have dodged a bullet at least for the time being but the potential to repeat the Victorian experience or worse is clear to all.

Long term changes in behaviour seem likely and wearing of masks may become de rigueur, as perhaps suggested by our front cover. A cottage industry for making fashionable masks exploded overnight and like **toilet paper** before it, the spot market in masks peaked. Wearing masks is currently only compulsory in Victoria but if you're handy at the sewing machine **NSW Health has the pattern** for you.

Dr David Guest
Clinical Editor

On page 12 Bulgarr Ngaru Medical Aboriginal Corporation describes its approach to dealing with COVID-19 in a high risk population. Their experience reflects that of many general practices around the country, but had to be tailored to the cultural norms of their patient population. Strict hygiene and social distancing were the main foci, with telehealth working well for this highly mobile population group, suggesting an increasing role for this in the future.

Telehealth is good but not a panacea. A virtual consultation will never replace face to face. On page 17 Keen Street Clinic practice manager, Debbie Elliott, makes this point and notes that for some patients, particularly the elderly, a visit to the clinic is falsely seen as high risk. Such patients can be reassured that anyone at risk of COVID-19 infection is not seen in GP surgeries but redirected to a hospital Fever Clinic or to the COVID-19 testing services run by the pathology companies. While repeat prescriptions can be organised through phone consultations, conditions such as heart and lung disease and chronic pain still need regular clinic review.

Australian Nobel prize winning immunologist, Peter Doherty, believes there is an **80% chance of a coronavirus vaccine** within the next 12 months. In his 2013 book **Pandemics** Doherty predicted how a global pandemic would spread, and his hypothesis has proven to be essentially correct. In an Australian Financial Review **Zoom lunch on May 8** his speculation on how Victoria might be affected by a second wave was remarkably prescient.

Doherty's predictions are based on his years of experience and on his close following of the multiple COVID-19 vaccine trials around the world, some of which are in late stage testing. While optimistic he cautions that it is only data driven science that will produce a successful vaccine. On page 37 Alstonville pharmacist, Alannah Mann outlines the latest Australian efforts to produce a coronavirus vaccine.

It took 15 years to develop the first vaccine against the 1919 Spanish influenza. Through the work of thousands of scientists like Doherty it seems feasible that a vaccine against a virus which did not exist a year ago could be accomplished in less than 12 months.

However, in science nothing is a given. It is only through rigorous scientific research that is statistically significant and reproducible that advances can be made. Progress marches to its own drumbeat and not that of the political cycle.

Nor does science care about publisher's deadlines. On page 22 Robin Osborne reviews "The Doctor who fooled the World" about the scandal surrounding Dr Andrew Wakefield who held that measles vaccination caused colitis and autism. Even well respected journals such as *The Lancet* can give credence to claims that are proved subsequently to be false. The public's concerns, or hopes, about new treatments can result in poor outcomes as seen by this episode and similarly with the recent claims for hydroxychloroquine in the COVID-19 pandemic.

Invest in basic research pleads the

Editorial: COVID-19 continues to dominate our lives

Australian Virology Society (on page 19) so that we are better prepared for the next pandemic. They make the case that such an investment is financially viable. The challenge for Australia is to commercialise these breakthroughs locally and create a sustainable Australian environment for innovative drug development and production.

Basic research over the last 20 years is now finding a place in day to day practice. Options for patients with arthritis, skin disease and cancer treatments are exploding.

On page 31 advanced oncology trainee at Lismore Base Hospital, Dr Ben Watson, outlines the current approaches to immunotherapy in haematology and oncology and on page 8 the doctors from the new North Coast Dermatology look at advances in the treatment of psoriasis through medications that affect the T helper cell 17 pathway.

On September 28 Drs Jenkins, Claudia Curchin and Hsien Herbert Chan from North Coast Dermatology are the presenters at the NorDocs webinar on psoriasis treatment for general practitioners. Members are encouraged to register at Eventbrite and join the presentation and subsequent Q&A.

NorDocs congratulates Drs John Vaughan and Austin Curtin on their awards in the **2020 Queen's Birthday Honours list**. **John** was a stalwart of the Port Macquarie medical community prior to his retirement and was recognised for his services to medicine and surf life saving. Austin Curtin has served the North Coast community for over 30 years as a surgeon and educator. On page 5 he reflects on his past, present and future in an interview with Dr Chris Ingall.

"The king is dead. Long live the king."

This is the first edition of NorDocs magazine and reflects the change in direction for the Northern Rivers General Practice Network, as determined at its last Annual General Meeting. NorDocs magazine is now sent to all medical practitioners between Grafton and the Queensland border.

The NRGPN's journal GPSpeak had been in almost continuous publication for 24 years and has reported and advocated on North Coast health matters for most of that time under the guiding hand of Medical Editor, Dr Andrew Binns.

GPSpeak thanks all our past readers and sponsors and hopes that NorDocs magazine will continue the tradition of serving the North Coast medical community, their patients and our general readers.

Musings on a North Coast medical career

Dr Chris Ingall talks to recent award recipient, Dr Austin Curtin AM

I'm enjoying a cup of tea with Austin Curtin, looking out at the huge fig trees that define his garden. It strikes me how their deep roots and strength allow such reach across the lawn, and how that is mirrored in Austin's approach to his vocation over nearly 40 years here in Lismore. He tells me of his decision to leave Sydney's Royal North Shore Hospital in the early 1980s and how it was viewed with bafflement by his peers, who saw no advancement in serving 'the bush'.

Dr Austin Curtin AM with medical students at the University Centre for Rural Health, Lismore.

You use the word 'serving' quite a bit. Does that come from your formative years?

Well I was Jesuit trained, and one of the Jesuit mottos is 'Men for Others', which articulates the idea of service developing self-worth. I'm also a third-generation doctor and I guess I was inculcated with medicine as a vocation rather than a job. I have always seen rural and remote medicine as needing a voice, deserving of more attention from what is still a strongly metropolitan-based health system. Indigenous health stands to gain from taking this perspective, and I have always thought it a privilege to represent both rural New South Wales and indigenous communities.

Why did you choose Lismore?

I knew Bill Buddie, and when I came to Lismore I saw it really was a centre of excellence for surgery even back then. Bill was always interested in the person who needed surgery, as well as the type of surgery he or she needed.

GP Andrew Binns was cut from the same cloth, and like Bill was interested in and active in the community. At North Shore where I trained, Graham Coupland and Tom Reeve were both impressive men and surgeons, with Tom one of the first advocates for clinical surgery to the government. Cliff Hughes was a cardiothoracic surgeon there who went on to head the Clinical Excellence Commission, so in a sense I feel I really do stand on the shoulders of giants.

What changes have you seen over the years?

There has been a real renaissance in rural and remote specialist medicine, not only for the coastal fringe but also inland, which is most gratifying. People can now finish their training and say they would like to go to Orange or Dubbo and no one will blink.

What we've got here in the Richmond Valley is very special, as we have the UCRH bringing students from a number of different universities to link with the specialist and GP training in this valley. We have built up great undergraduate and junior doctor teaching, a rural hub for registrar development and I am very excited about now supporting a research initiative for consultants through the Curtin PhD scholarship for Postgraduate Clinical Research in Indigenous and Rural Health.

I would like to think we have reached a 'critical mass' of specialists and GPs, to ensure this will continue to build.

They say you get your gong for all the things you do that you aren't paid for.

[Ed: In 2020, Dr Curtin was honoured as a Member in the General Division for the Order of Australia for his significant service to medicine and health outcomes in regional communities].

My involvement with junior doctor training from the very early days of the Postgraduate Medical Council right through to sitting on the board of IMET, which became CETI and now HETI, chiefly as a rural voice. I can't tell you the number of hours I have sat through Sydney-based meetings, before we had the Skype and Zoom connectivity we have now, but I do feel they have been fruitful, as we see our Rural-based Preferentials training in our hospitals and building a sense of local ownership in clinicians in their training.

We are no longer just a Metro spoke but very much a Rural hub, and that also will continue to grow.

What are your plans now?

I feel fortunate to still be in reasonable health and I'm hoping to spend more time with my wife Annie and the family. The kids and grandkids are well spread geographically, so I have taken up flying so I can visit them more frequently.

It's certainly a buzz and I'm really enjoying it. I have also taken up golf, which is arguably enjoyable, and enables some good bonding with my mates. Mind you, I do wonder whether I will be able to take my eye off rural health completely... so watch this space.

Further background on Dr Austin Curtin is available on the **SCU web site**.

From the inside out

Handover of medical care in the North Coast's mega-prison

Dr Andrew Binns visits Australia's newest, biggest and potentially most controversial prison.

The City of Grafton is a place of mixed blessings. Famed for its annual Jacaranda Festival, when street trees burst into purple blossom, it is also the place where a stone-walled jail, opened in 1862, drew criticism over the years for the cruelty of its warders.

Now the area is becoming famous for the establishment, at a nearby location, of Australia's newest and biggest prison, the Clarence Correctional Centre (CCC), a 1700-prisoner facility that state MP Chris Gulaptis (Nats, Clarence) hails as having "world class facilities" and offering a "responsible prisoner model" offering job search prospects upon release

Gone are the days when arrivals at Grafton jail were forced to run the gauntlet of baton wielding warders positioned to show new prisoners who was boss. The ritual was known as the "reception biff" and drew condemnation from the Nagle Royal Commission into NSW prisons.

In this new era, as Mr Gulaptis extolls, "prisoners will be able to use tablets for visits, bookings, employment scheduling and study."

Local employment opportunities are touted as a major benefit to the economy of an area experiencing even greater social disadvantage than the Northern Rivers generally, a region facing many challenges, despite its appeal as a tourist destination.

Following the construction phase, when the workforce peaked at around 1,200, the CCC is said to employ 600 people. Up to 1000 beds will be in maximum security, with at least 30 prisoners released per day. Alarmingly, it is estimated that 50 per cent of these will become homeless upon release. The area bounded by Tweed Heads and Coffs Harbour, including Byron Bay, has a high homeless state and a disturbing number of 'rough sleepers'.

Questions have been raised about the capacity of community health organisations, including the regional hospitals (Grafton, Coffs Harbour and the smaller Maclean facility are the closest), to deal with a likely increased workload.

Photo L-R: RN Balund-a/Jullums John Llewellyn, CEO Rekindling the Spirit, Georgina Cohen, GP Andrew Binns and GP Peter Silberberg

An extensive report conducted this year by the not-for-profit Social Futures, in conjunction with the Deloittes consultancy, assessed Clarence Valley's health and social service capacity. The document has had no public release and has only been circulated to organisations involved with the care of released prisoners – with a legal injunction implying action in the event of any 'leaks'. Questions from this magazine about the report's findings have not been responded to.

One significant problem identified is a shortage of housing in the region for prison staff and prisoners' families, as well as concerns about already overloaded regional health and social services being able to handle the expected increased workload.

A key issue for GPs and other health professionals who may be asked to care for released prisoners is the secure encrypted transfer of medical records to their practice. Major advances have been made with this between public hospitals and GPs over the last two decades. The same is urgently needed from NSW Justice Health to GPs wherever they practice.

If Governments are serious about reducing our high recidivism rates a range of social and cultural determinants of health need to be addressed and properly funded. There needs to be more emphasis and money spent on diversionary health measures to address complex chronic mental and physical health diseases, domestic violence, homelessness matters, and so on.

The continuing 'tough on crime' approach is especially failing Aboriginal and Torres Strait Islander prisoners, for whom incarceration rates are still rising disproportionally. There is no reason to think this will not be seen in Grafton's CCC.

Within this context, it is encouraging to see the 16 items on the 2020 Closing the Gap targets, in particular target number 10. The outcome aimed for this is that Aboriginal and Torres Strait Islanders adults should not be over-represented in the criminal justice system. The target by 2031 is to reduce the rate of ATSI adults held in incarceration by at least 15 per cent.

The big question is how is this to be achieved? An article called Spiritual Fatigue

on page 10 by Gamilaraay academic, Prof Bob Morgan explains how the social and cultural determinants of health need to be the focus. On page 24 there is also an article on ways to reduce the number of young people incarcerated by targeting those with cognitive impairment and referring them to a diversionary program rather than sending them prison for a relatively minor crime.

A recent visit to the CCC (photo opposite) by CEO Rekindling the Spirit, Georgina Cohen, RN Balund-a/Jullums John Llewellyn, GP Peter Silberberg and myself was an eye opener for its size and infrastructure. It has the most advanced systems imaginable for secure incarceration.

Contraband smuggled into jails is a worldwide problem and happens significantly in Australian jails too. The measures to reduce this problem were demonstrated to us, with security systems far more sophisticated than an airport.

While there were no barred windows there were plenty of near impenetrable, see-through ones. We were shown the emergency health facility, similar to what one may see in an accident and emergency department in a rural public hospital.

We spoke with Serco's Health Services Manager Stephen Joyce and Dr Trish Collie, an addiction specialist physician. Important issues for us were addressed by the health team and good progress was made in developing a professional working relationship. Sharing medical records after custodial patient consent with primary health care teams, wherever they may be, was a discussion priority.

Whatever one's view on the issues surrounding complex cultural, socioeconomic, historical and trauma issues that often lead to imprisonment, there is an opportunity with this new facility to address health issues for such prisoners, whether as inmates or post-release. It is up to us all to respond as best we can and to advocate for the health and wellbeing of this severely disadvantaged group in our community.

Sheds provide shelter for bushfire survivors

Jubullum Aboriginal community member Daniel Walker, Vinnies St Therese Casino Conference president Marlene Landrigan, The Shed of Hope's Greg Dollin and Vinnies Richmond Regional president Michael Albany with the donated water tank.

The message came to Greg Dollin in a dream: "I was wondering what practical help we might offer those unfortunate people whose homes had been destroyed in the bushfires, and then it came to me... call it a message from God... we could build sheds where they live with their families while assessing the damage and beginning to rebuild their lives."

It was January 2020, and the fires that had swept through farms and bushland to the west of Casino were finally being brought under control. Rappville was one community badly affected, with homes lost and the Tarmac sawmill, run by the biggest local employer, burnt to the ground.

Property owners on remote holdings around Tabulam, where Greg is based, were among those affected, with buildings gone and vital infrastructure such as solar equipment, water tanks and pumps destroyed.

An adept handyman and something of an inventor, Greg started to create something that was new even for him - a charity that came to be called Shed of Hope.

Relying on donated funds, including a massive $60,000 transfer from a US charity, Shed of Hope has now built around 40 habitable sheds on properties between the Richmond and Clarence Valleys. It is headquartered in a gigantic shed in Tabulam filled with donated furniture, non-perishable food and personal items that are delivered to, or collected by, people still struggling to cope with the impacts of the bushfires.

In Greg's view, the full recovery is likely to take from five to eight years, with most rural landholders having little choice but to remain on their properties, hence the need for the sheds, built by the charity's volunteers using largely donated materials. They also undertake site remediation to help get the rebuilding process started.

Shed of Hope's HQ has become a major hub for the distribution of bushfire relief, including water for the many locals whose tanks were destroyed by fire. Vinnies is one of the charity's partners and recently donated a new 22,500 litre tank to collect rainwater for filling the portable containers brought in by outlying residents.

"Like Vinnies, we're here for the long haul," Greg said.

"The more you get around, the more you realise how badly affected so many people have been. The shed project enables them to stay on their land, and live at least half-comfortable lives while they engage in the rebuilding."

Bridging the troubled waters of psoriasis

by Drs Jenkins, Curchin and Herbert Chan from North Coast Dermatology

Kim Kardashian West, Cyndi Lauper and Art (*Bridge Over Troubled Waters*) Garfunkel are some of the world's famous psoriasis sufferers, but lest the condition be thought to disproportionately affect singers, others in the celebrity club include author John Updike and golfer Phil Mickelson.

If the disease doesn't target occupations it does tend to run in families – KKW's mother is also a sufferer – but fortunately treatment options for patients with psoriasis have evolved considerably in recent years. Advances in dermato-immunology have been especially encouraging, with targeted "biologic" treatments for severe psoriasis.

Nine monoclonal antibodies are now available on the PBS for patients who have failed some of the more traditional treatments, and have a persistently high Psoriasis Area and Severity Index ("PASI score"). In this article we review the treatment options available, as well as aspects that are of particular interest to the general practitioner.

Psoriasis Treatment overview

Mild psoriasis can often be controlled with removal or avoidance of triggers, in conjunction with topical treatments which include emollients, topical steroids, tars, keratolytics, calcipotriol, and less commonly dithranol, topical calcineurin inhibitors, and retinoids. These treatments are often used in combination.

Another important first line measure is lifestyle change. Healthy living, managing stress, minimising alcohol and tobacco consumption are all thought to improve psoriasis in some people, and will mitigate against some of the metabolic associations of the disease. There is good evidence that weight loss in particular can have a tangible impact, not only on the psoriasis itself, but in sensitising patients to the effect of other treatments.

Step up treatments are usually required if these initial therapies are unsuccessful or unsuitable, the areas that are involved are likely to be resistant (e.g. nail psoriasis), or if the psoriasis is assessed as moderate or severe from the outset, and control with the agents used for mild psoriasis is unlikely. These measures include phototherapy (most commonly delivered as narrowband UVB), systemic retinoids (e.g. acitretin), or systemic immunosuppression (e.g.ciclosporin or methotrexate).

Whilst they are an excellent treatment for many patients, these traditional immunosuppressants have less efficacy and tolerability than the injectable biologic agents that target a specific immunological phenotype that is upregulated in psoriasis.

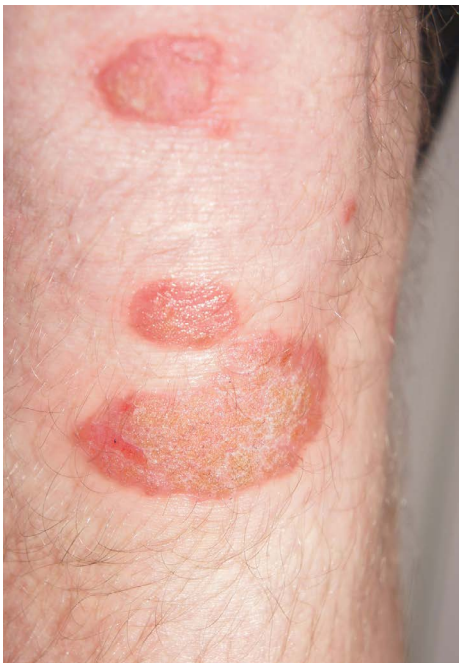
The most successful drugs have targeted the Th17 pathway, especially the IL-17, and IL-23 cytokines, although anti TNF agents were the first drugs in this category, and are still in use. Anti IL-23 antibodies (Guselkumab, Tildrakizumab, Rizankizumab), anti IL-17 antibodies (Secukinumab, Ixekizumab), anti IL-12/23 antibodies (Ustekinumab), and anti TNF antibodies (Adalimumab, Infliximab, Etanercept) are all PBS approved for severe psoriasis that is not responsive to other therapies.

Approximately half of all patients with severe psoriasis can expect a complete clearance of their skin with the newer biologics, with the vast majority of the others enjoying a significant improvement.

Patient and GP awareness of the available therapies

Clearance (or at least optimal control) is usually achievable for patients who want it. Exactly what constitutes good control is different for each patient. Setting the metabolic associations of psoriasis aside, the impetus for treatment will be determined not only by the severity of the psoriasis, but also the affected sites, associated symptoms (itch, soreness, flaking/dandruff), and the patient's wishes.

Whilst the concern for patients with psoriasis isn't usually mortality, it often has a high morbidity. It will be of use for practitioners to know that for most patients the benefits of treatment usually outweigh its risks. If psoriasis isn't adequately controlled with avoidance of triggers, lifestyle changes and topical therapies, then escalation to phototherapy or systemic treatment is indicated.



Psoriasis image - www.paul-hat-schuppenflechte.de / **CC BY-SA**

In the age of "Dr Google", many patients will come to the GP having researched or heard about newer treatments that they would like to discuss, and it will be helpful for GPs to have an awareness in general terms as to where they fit in an Australian context. Conversely, there are still many patients with significant, treatable, chronic psoriasis that have inappropriately resigned themselves to thinking that they have to live with it.

A therapeutic alliance with the dermatologist

GPs play a critical and ongoing role in the health of psoriasis patients. Dermatologists will be looking to engage in a therapeutic team with the GP as they are particular keystones in:

- Optimisation of triggering medications. Certain medications, e.g. beta blockers, can exacerbate psoriasis and sometimes alternatives can be found that are equally therapeutic.
- Assessment and treatment of cardiovascular risk factors, psoriatic arthritis, depression/ anxiety and social supports.
- Weight loss counselling/planning.
- Smoking cessation.
- Working with the dermatologist to address any workforce implications.

• Some systemic therapies are contraindicated or at increased risk of complications with harmful alcohol intake, suboptimal blood pressure and diabetic control. Minimisation of these factors is very helpful.

• Supplying an up-to-date complete medical and medication history, as many systemic therapies have contraindications or interactions.

• Providing a central point of care, especially when multiple specialists are involved (e.g. for rheumatic or ocular complications, or comorbidities).

General Practitioners play an especially important role with patients on systemic therapies, especially in the lead up to initiation of a biologic. Considerations include:

• Monitoring for toxicities of ciclosporin – blood pressure and renal especially.

• Pre-immunosuppression work-up for the presence of chronic infections, autoimmunity or malignancy. Dermatologists will often order tests looking for tuberculosis, Hepatitis B and C, HIV, strongyloides exposure, varicella immunity, autoimmunity, paraproteinaemia. However, they rely on the GP to ensure that age-related malignancy screening is up to date, as immunosuppression should be avoided in the setting of active malignancy. A history of malignancy in the previous five years is a relative contraindication to immunosuppression.

• Ensuring vaccinations are up to date. Live vaccines are best given before treatment is started, as treatment must be stopped and washed out (with long half-lives) if a live vaccine is to be given. Inactivated vaccines are also best given off treatment to maximise the immune reaction, however, these can be given whilst on therapy if required.

• A travel assessment is beneficial to try and predict and plan for any indicated immunisations.

With more in the therapeutic toolbox, and collaboration between health practitioners, psoriasis patients can look forward to better outcomes. Indeed a bridge over troubled waters!

New dermatology practice "hasn't looked back"

L-R: Dermatologists Drs David Jenkins, Claudia Curchin and Hsien Herbert Chan

Three dermatologists with strong connections to the Northern Rivers area have collaborated to form a new specialist practice, North Coast Dermatology, based in the Byron Bay Specialist Centre on Jonson Street.

Australasian College of Dermatologists-certified doctors Claudia Curchin, Hsien Herbert Chan and David Jenkins opened North Coast Dermatology in March this year, and haven't looked back since the first patients arrived.

The practice treats all skin, hair, nail and mucous membrane problems. They explained: "Skin conditions such as keratinocyte skin cancer, melanoma, eczema, dermatitis, psoriasis, acne, vitiligo, hair loss, uncontrolled sweating, genital and oral dermatology, paediatric dermatology and contact dermatitis/allergy are very common, and form the basis of our work. As the interface between our inner health and the environment, the skin has the largest number of pathologies out of any organ – over 4000!"

Each dermatologist has published in peer-reviewed local and international publications, and worked as staff specialists in tertiary referral public hospitals. Dr Herbert Chan has a particular interest in research, and both he and Dr Curchin have undertaken additional training in confocal microscopy. The team brings together a wealth of specialist dermatology experience and expertise.

Founding North Coast Dermatology has been a homecoming of sorts. Dr Curchin grew up in the Northern Rivers, as did the partners of Dr Herbert Chan and Dr Jenkins. Both Dr Curchin and Dr Herbert Chan have been practicing locally for several years now, and Dr Jenkins has been working intermittently in the region.

The practice considers patient safety as paramount, so during the COVID-19 pandemic they have been rigorously screening patients for any illness before they enter the practice, which ensures a safe experience for all. At present, North Coast Dermatology is open Monday through Thursday, and is located at suite 6, 130 Jonson Street, Byron Bay. They are always happy to fit in urgent cases, and encourage General Practitioners to contact the practice (ph: 6685 8433), or individual dermatologists, if there is anything they can help with.

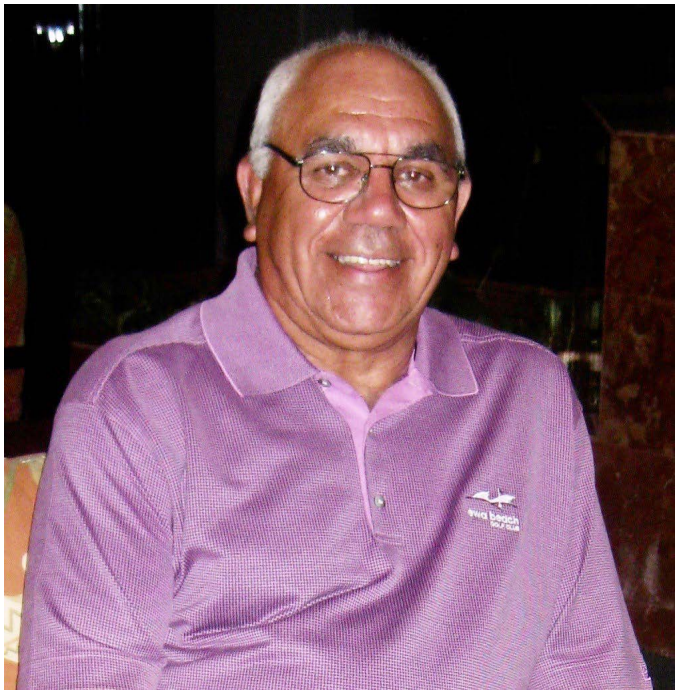
Spiritual Fatigue

A key determinant of health status for Australia's Indigenous peoples, as Professor Bob Morgan explains.

Australia may be envied abroad for its material riches but most Aboriginal people continue to struggle to overcome the ravages of poverty, the contamination of our cultures and traditions, the impacts of dispossession, the alarmingly disproportionate levels of incarceration and the effects of racism and socio-political alienation.

All of these elements are determinants that help to understand the debilitating health status of Aboriginal and Torres Strait Islander people.

In Viktor Frankl's seminal book Man's Search for Meaning (1938) on the theory of logotherapy, based on his observations from his time in German concentration camps, he argued that, "The human being is an entity that consists of a body (soma), mind (psyche), and spirit (noos)." He explained that we have a body and mind, but the spirit is what we are, our essence. Note that Frankl's theory was not based on religion or theology, but often had parallels to these.



Professor Bob Morgan, Chair, Board of Aboriginal and Torres Strait Islander Education and Research (BATSIER) University of Newcastle

In an Aboriginal context I maintain that Aboriginal people suffer a form of what I refer to as 'Spiritual Fatigue', a debilitating consequence of having to either constantly struggle for human rights and freedoms or being forced to constantly defend them. There is no room for celebration and meaning in this paradigm - it is simply a choice between struggle or defence.

Spiritual fatigue aligns with Frankl's theory of Logotherapy but it is more profound than that. This is due in part because Aboriginal people continue to suffer transgenerational trauma that forces them to deal with a number of effects resulting from being disconnected, and in some cases forcibly removed from Country, some of which holds important and sacred meaning that has been developed over a thousand generations. It is also important to understand that when Aboriginal people speak of Country this extends beyond mere notions of geography.

Added to this is the destruction of Aboriginal languages, the contamination and/or erosion of culture and traditional values, the destruction of age-old lores that have governed and regulated how Aboriginal people lived with each other and with the environment and other forms of life. It involves a loss of purpose and meaning, all of which can be traced to various public policy and social attitudes, the net result is the health disparities, the social inequalities and political marginalisation that defines the life of Aboriginal people in 21st Australian society.

The current alarming rates of Aboriginal incarceration, often the consequence of poverty and cultural erosion, the appalling health inequalities, the ongoing failure of the Closing the Gap (CTG) strategy and numerous other indicators point to the need for a radical resetting of the way that Aboriginal needs and aspirations are identified and responded to.

Increasing evidence-based research illustrates that the greater the involvement of Aboriginal people the more connected to Country they are, the greater the opportunity there is for the practice of lore and the reimagining of purpose and meaning.

We must ask ourselves why non-Aboriginal Australia and our political leaders remain unable, or unwilling, to accept this essential truth. They appear to be wedded to another truth, a form of collective cognitive dissonance... and so the suffering continues.

When considering chronic disease patterns, Professor Garry Egger explains: 'It's a mistake to think that there is a single cause of chronic disease. Instead there's a 'hierarchy of causality'. This is shown in the diagram:

- First there is the disease (short list shown here)
- Then there are 'risk factors' or markers for these diseases
- But there are a range of 'determinants' (not really 'causes' in chronic disease)
- First, there are the 'proximal' (downstream) risk factors, which are closest to the disease (this is one 'cause')
- But there are 'causes' of these and they are 'medial' or midstream,
- But these also have 'causes' and these are called 'distal' or the 'cause of the cause of the cause'). And this is where most analysis usually ends,
- But somewhere between the distal and other levels of causality are the psychological factors that are important for displaced societies.
- These are meaningless, alienation and loss of culture and identity, which are profound for Indigenous cultures.

CTG – a failed Public Health policy

When viewed through the prism of Aboriginal experience, the notion of 'closing the gap' implies, perhaps unintentionally, that the underlying causes of the devastating health conditions experienced by most Aboriginal peoples are mirrored in non-Aboriginal society, and therefore Aboriginal inequalities will

be best addressed if health systems and providers simply focus on 'the gap'. This ignores the many factors that underpin the burden of poor Aboriginal health.

These factors include the burden and the nature and scope of dispossession, the contamination of cultures and government sanctioned attempts of genocide, entrenched poverty, racism and the ongoing denial of the fundamental and unique rights and freedoms of Aboriginal peoples in Australia.

Clearly the current strategy is not working, suggesting that a new policy approach should be adopted. Such an approach should be designed to develop effective and empowering negotiated partnerships with Aboriginal people, particularly at the local community level.

Incorporated into any new policy approach should be targets for truth telling and social and restorative justice.

Increasingly research is telling us something that Aboriginal peoples have always known: it is only when Aboriginal people are in control of their own lives do we witness a real shift in the socio-political circumstances, including health, that defines the life journey of most Aboriginal people.

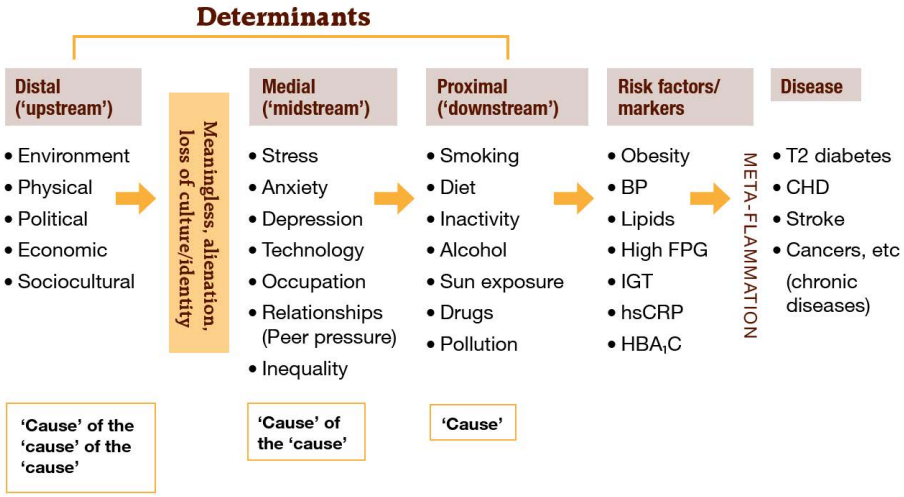
Currently in Australia there are three sites where research is being conducted that is exploring what a new model of community governance might look like.

These communities are the Gunditjmara people in Victoria, the Ngarrindjeri nation in South Australia and groups and individuals from the Wiradjuri nation in NSW.

The Australian research is based on the Harvard Project wherein researchers work in partnership with First Nation communities in the USA to explore new models of Indigenous governance and economic development. The research from that project tells us that:

Sovereignty matters - When Aboriginal nations make their own decisions about what development approaches to take, they consistently out-perform external decision makers on matters as diverse as governmental form, natural resource management, economic development, health care, and social service provision.

A hierarchy of disease 'causality'



Institutions matter - For development to take hold, capable institutions of governance must back the assertions of sovereignty. Nations do this as they adopt stable decision-making rules, establish fair and independent mechanisms for dispute resolution, and separate politics from day-to-day business and program management.

Culture matters - Successful economies stand on the shoulders of legitimate, culturally grounded institutions of self-government. Indigenous societies are diverse; each nation must equip itself with a governing structure, economic system, policies, and procedures that fit its own contemporary culture.

Leadership matters - Nation building requires leaders who introduce new knowledge and experiences, challenge assumptions, and propose change. Such leaders, whether elected, community, or spiritual, convince people that things can be different and inspire them to take action.

The research emanating from the Harvard Project indicates that there is an obvious and urgent need to shift paradigms if real and sustainable traction and meaningful outcomes are to be achieved in Aboriginal health, poor education experiences and learning outcomes, disproportionate incarceration rates, poverty and spiritual fatigue.

If long overdue and sustainable change is to occur it will require the design and adoption of a new model of engagement, one that empowers local communities so that Aboriginal people are in greater control of their lives and how best to address their needs and aspirations.

Health systems in NSW, and equivalent bodies in other health jurisdictions, must work with local Aboriginal communities to negotiate an Aboriginal Health and Wellness Accord, which is underpinned by a set of clearly defined and community endorsed principles and strategies that are designed to, implement, monitor and continuously evaluate progress against agreed local Aboriginal health and other social justice targets.

There is no 'one size fits all' solution to address the long-denied rights and freedoms of Aboriginal people, including health inequality and the right to live free of poverty, racism and discrimination, and with dignity.

Even in the face of brutal indifference and pathological racism, not to mention the intransigence that defines the political and societal treatment of our uniqueness as the First Australians, Aboriginal people have survived.

Change and transformation in the health status of Aboriginal people requires a shift in policy and programming and in the hearts of power. A shift that creates empowering involvement of Aboriginal peoples through negotiated partnerships between health and other service providers and members of Aboriginal communities.

How an Aboriginal Medical Service handled COVID-19 risks

by Scott Monaghan, Andrew Black, Marion Tait, Hannah Visser

Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC) was established in 1991 to provide health services to the Aboriginal communities of the Clarence Valley, and now operates a regional network of comprehensive primary health care services covering the traditional clans of the Yaegl and Gumbaynggirr Nations and a large proportion of the Bundjalung footprint.

BNMAC provides services to communities from Tweed Heads to Grafton, including Grafton, Baryulgil, Malabugilmah, Yamba, Maclean, Casino, Box Ridge, Muli Muli, Tabulam, Kyogle, Tweed Heads South, Chinderah, Fingal Heads and Banora.

The emergence of the global pandemic necessitated BNMAC, like society at large, to respond to unprecedented circumstances. The extensive media coverage, the incessant social media postings, even conspiracy theories, heightened the confusion and anxiety felt by many in the Aboriginal community. The economic situation of disadvantaged communities added to this anxiety.

From the start we knew that access to reliable and timely information about the virus was important. Soon BNMAC took on the role of trusted information broker in regard to the virus. Facebook proved a viable platform for disseminating accurate information to the community. This was supplemented by BNMAC health workers communicating important information through their networks.

In developing a response to the new circumstances, social and cultural matters relating to the Aboriginal community were thought through carefully and consulted upon with the community and the Aboriginal staff at BNMAC. We recognized that the Elders had to be protected, given their custodianship of community knowledge and their role in Aboriginal community life.

They bring much-needed resilience to the community. The multigenerational nature of Aboriginal communities introduced an important consideration. The children in Aboriginal communities move freely and are cared for by the older folk and enjoy a closeness to them. This presented a potential risk, as the children could become unwitting vectors for the spread. Also, living arrangements in the Aboriginal community often accommodate many in the same household, making quarantine or self-isolation harder.

The mobility of the Aboriginal population was another important consideration. We thought small in-land isolated towns such as Tabulam provided a layer of protection; little did we think that family members in large cities during lock down may seek to escape the loneliness and restrictions imposed on them. They came to enjoy the freedom that these small settlements offered. Coastal towns such as Yamba that have a substantial Aboriginal population, though isolated, are surrounded by wealthy, retired non-Aboriginal populations that undertake travel and cruises, which could unintentionally expose the Aboriginal community to health risks.

In BNMAC, like other services, we were initially unsure how to prepare our response to this health crisis, and the community was uncertain how to protect itself. Our existing plans and procedures were not adequate for responding to a pandemic of this nature. We had to act quickly, adapt, and develop an appropriate response. We updated our flu pandemic plan, modified the infection control procedures, and adjusted care delivery.

After a review, to minimize and mitigate the risks of exposure for the workforce as well as the community, the number of locations from which clinics were offered was reduced. We developed a workforce strategy and stratified staff by personal health risks and took steps to protect them. This guided the arrangements for BNMAC staff who worked from home and those who continued to work from the clinics.

The clinic waiting rooms were rearranged to ensure patient physical distancing, with clearly marked patient and clinician zones. We exercised many site drills and simulations involving the entire workforce in the clinic – starting with the receptionists and the important role they played in ensuring safety and management of sick patients with potential COVID-19 exposure and communicating with patients unable to quickly understand the instructions.

A process was established early on to stratify and prioritize the care of patients with highest risks. Those aged 40 and over with more than one chronic ailment were categorized and each patient's health profile closely examined. The most vulnerable were listed. Our clinicians were also given the opportunity to add other patients to the list, at whatever age, that they considered susceptible.

Weekly or fortnightly contact was made with these at-risk patients by a nurse or Aboriginal health worker to carry out a 'well-being check'. Through the conversations it was determined whether

GP consults were needed, either face-to-face or by telephone. This ensured the patients received holistic and team-based care. In addition to this list of patients, other individuals, particularly at-risk young men not seen for some time, were identified by our Aboriginal health workers and contacted.

This period proved that telephone consults are an effective option for delivering GP primary care. The introduction of telephone consultation was carried out carefully and with due consideration of the circumstances of the Aboriginal community. The video consultation option was discounted since many in the community do not have the required phone data. At the outset an 1800 free call number was established. The patients were often offered a phone consult with the GP and then it was determined whether a face-to-face consult was necessary.

While face-to-face is still the best option for care, this intense period proved telephone consults to be an excellent addition to the service options available to the community. Telephone consultations facilitated swift communication with patients and provided the capacity to respond in a timely manner and with greater agility; both in creating care plans and in providing care.

The community members have appreciated having this health care option and most have embraced it. Telehealth has improved health care access for patients, eliminated transportation barriers, and facilitated quick communication between practitioners and patients. This consult option also meant that patients who might miss appointments did not need to wait for another week or so to see the doctor. The number of no-shows was reduced.

Furthermore, GPs have noted that clients spoke more readily and freely on the phone; some clients who usually said little in face-to-face consults spoke at length. There was also an upside for some mental health patients. Those with severe anxiety were comfortable to receive care at home.

Another important learning was related to diagnostic test result. The average time for test results to be communicated to patients is about three weeks, unless prioritized. During this period, given that the patient consult was on the telephone, the time was reduced significantly to just a few days. Additionally, the process set up for specialist consults for patients by phone worked very well, and notably the specialist response, and the receiving of patient notes and letters, were faster than usual.

A few fever clinics were initially established in major local hospitals. Vulnerable patients in outlying areas with limited transport found it difficult to access these clinics and chose to go to Aboriginal Medical Services for their care. The eventual establishment of fever clinics by BNMAC in collaboration with the Local Health Districts (LHD) proved an effective model.

Adversity and challenging times bring opportunities for change and advancement. During this difficult period, we witnessed a significantly increased openness to change. Clinicians and communities were receptive to changes that otherwise they might have been reluctant to consider. During this time, we were able to introduce and establish innovations under consideration for some time.

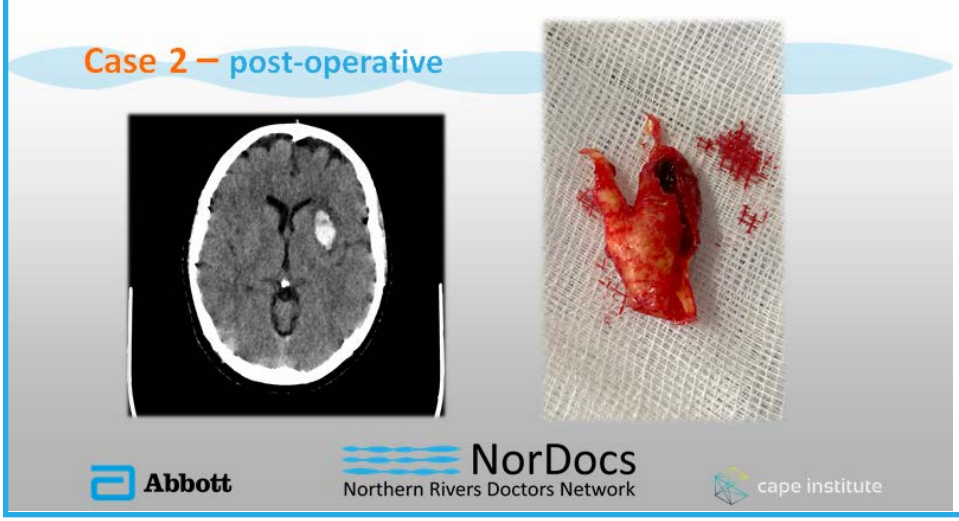
For example, we developed partnerships and established joint integrated clinics that previously would have taken months, even years. We changed care delivery models with agility and effectiveness. And importantly, this period of change has given the community confidence and courage to do things differently. We are determined to sustain these improvements.

It is in periods of significant change that strong leadership, trust, and goodwill at the community, clinician, and management levels are needed. We have seen this in abundance. We want to systematically document our experience and the knowledge gained, reflect on these, and use them to make sustained changes.

Mr Scott Monaghan is the Chief Executive of BNMAC; Dr(s) Black, Tait and Visser are General Practitioners at BNMAC.

BNMAC acknowledges the support of VSA Australia in documenting its COVID-19 experience. Email for VSA Australia **vahid@saberi.com.au**

NorDocs kicks off its Webinar Series



The inaugural NorDocs webinar was held on Saturday 8 August, 2020, on the subject of "Timely Carotid Artery Disease Management".

The meeting featured local physician, Dr Jowita Kozlowska, and vascular surgeon, Dr Dom Simring. It was produced in conjunction with **the Cape Institute** and was generously sponsored by Abbott Vascular.

The webinar was recorded and is **available from the NorDocs Vimeo site.** The password for the recording can be obtained from the **NorDocs Facebook page.**

Live & on-demand webinar series

Community of Learning

Gold Coast Private Hospital offers General Practitioners (GP) and healthcare professionals a series of live and on-demand educational webinars. Join us live to become a part of the discussion or view the recording at a time that suits you best, on any device.

Live – Save the date

Watch live and be a part of the discussion

Topic	Date	Presenter	Chair	RACGP
Osteoporosis in Primary Care	20.08.2020 6.30pm – 8.00pm	Dr Louise Ciin Endocrinologist	Dr Sharon Thomas General Practitioner	3 points
Cardiology	03.09.2020 6.30pm – 8.00pm	Assoc Prof Kuljit Singh Cardiologist	Taking expressions of interests	3 points
Paediatric Orthopaedics	17.09.2020 6.30pm – 8.00pm	Dr Annabelle Stabler Paediatric Orthopaedic Surgeon	Dr David Stabler Orthopaedic Surgeon	3 points
Endoscopy	01.10.2020 6.30pm – 8.00pm	Dr Kashif Sheikh Gastroenterologist	Taking expressions of interests	3 points
Cardiology (PFO)	20.10.2020 6.30pm – 8.00pm	Dr Ross Sharpe Cardiologist	Taking expressions of interests	3 points
Paediatric Orthopaedics	29.10.2020 6.30pm – 8.00pm	Dr Annabelle Stabler Paediatric Orthopaedic Surgeon	Taking expressions of interests	3 points
Women's Health	13.11.2020 6.30pm – 9.00pm	Grace Private Women's Health Specialists	Grace Private	5 points

For more details and to register, email: narelle.morrison@healthscope.com.au

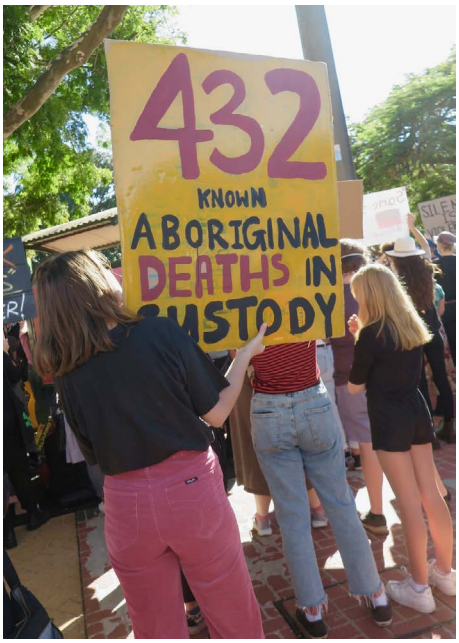
On-demand

Watch anywhere, anytime

Topic & Presenter	Presenter	RACGP	Instructions
Hand injuries in General Practice	Prof Randy Bindra Hand, Wrist & Nerve Surgeon	3 points	Free access for healthcare professionals at: **www.praxhub.com** Register, log in, and follow the Healthscope page to access all Community of Learning CPD videos. GPs are invited to view accredited videos, complete the online evaluation form, and your CPD points will be sent to the RACGP within 4 weeks.
Renal Cancer	Dr Christopher Tracey Urologist	3 points	
Bunions	Dr Simon Platt Orthopaedic Surgeon	3 points	
Cervical Screening Program	Dr Graeme Walker Gynaecologist	3 points	
Mental Health in General Practice	Serene Health Physchiatrists	5 points	
Bariatric Surgery	Dr Harald Puhalla General & Bariatric Surgeon	3 points	

For more information, topic requests, involvement or to join our mailing list email:
alix.irby@healthscope.com.au

Black lives mattered for thousands at local rallies



Photos of the Black Lives Matter rally in Lismore were taken by our editor, Robin Osborne.

On Saturday 4 July crowds estimated at up to 5000 in Byron Bay and more than 1000 in Lismore gathered for Black Lives Matter rallies in solidarity with African-Americans experiencing police brutality and Aboriginal deaths in custody in Australia.

Although the local federal MP Kevin Hogan (Nats, Page) described the Lismore rally as "not okay" because of COVID-19 risks, protest organisers insisted the time was right to shine a spotlight on the "ongoing systemic racism" in this country. Rally volunteers moved through the crowd to offer hand sanitiser and masks to anyone who came without them.

In Lismore Widjabul woman Cindy Roberts encouraged attendees to form a circle of unity and solidarity, and a number of local Police joined in. Protester Maddy-Rose Braddon said, "The police were invited to join too and they did. We all got on one knee with our fists in the air to demonstrate our solidarity with the black lives matter movement to end racist violence and deaths".

Many placards featured the words "I can't breathe", as expressed by George Floyd Jr who was killed by a Minneapolis police officer in May. Other signs mourned the 2015 death of David Dungay who used the same words whilst being held down by Long Bay prison guards.

Mr Hogan said that while he believed "Black lives do matter" he felt the health risks outweighed the need to demonstrate. However, no positive tests for the COVID-19 virus have been linked with the rally, nor, as far as is known, with any of the other Black Lives Matter protests held around Australia on the same day.

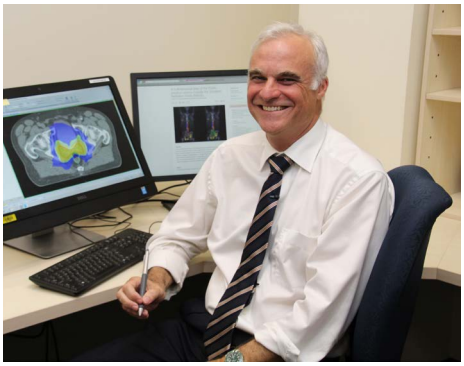
Top marks for region's breast cancer care

An evaluation of treating breast cancer with a combination of surgery and post-operative radiation therapy has found significantly improved long-term outcomes and substantially reduced side effects of treatment.

Radiation oncologist Associate Professor Tom Shakespeare, who works in the Northern NSW and Mid North Coast Local Health Districts, said more than 3,500 women had been treated with curative breast radiation at the Mid North Coast Cancer Institute (MNCCI) in Coffs Harbour and Port Macquarie, and at Lismore's North Coast Cancer Institute (NCCI).

"Breast cancer can be cured with a combination of surgery and post-operative radiation therapy," Assoc Prof Shakespeare said.

So successful are the techniques that a team led by local cancer experts has published an Australian-first evaluation of the curative approach in the Royal Australian and New Zealand College of Radiologists' Journal of Medical Imaging and Radiation Oncology.



Each year, around 260 women are diagnosed with breast cancer in Northern NSW and 190 on the Mid North Coast, according to Cancer Institute NSW figures. The treatment techniques evaluated include hypofractionation (treating in fewer sessions), intensity modulated radiation therapy (highly targeted) and treating women in the prone (face down) position.

The evaluation followed 155 patients from the Port Macquarie, Coffs Harbour and Lismore areas who were treated using this technique. The Northern NSW LHD invested $25.3 million in Cancer Services across the region in 2019-20.

"These new techniques are able to substantially reduce the side-effects of treatment, in particular, prone breast positioning is beneficial as radiation is distributed evenly and accurately, limiting exposure to the rest of the body," Assoc Prof Shakespeare said (photo left).

"The combination of these three techniques has been in use at the MNCCI and NCCI since 2012, and we were one of the first centres in Australia to adopt this method."

"Our report is the first of its kind in Australia, and only the second publication of its kind in the world," he added.

"We report on outcomes five years after radiation therapy. In our evaluation no patient had a cancer recurrence in the treated breast. We also found that no patient had significant side effects, and all evaluated patients rated their cosmetic outcome as good or excellent."

Bringing patients back is next COVID-19 challenge

Many patients have become so attuned to telehealth that encouraging them to return to face-to-face consultations with their GPs will become a major challenge in the post-COVID-19 era. If achieving an appropriate balance cannot be managed there are clear signs that people's health could be adversely impacted by conditions that have nothing to do with the coronavirus pandemic.

This is the view of many primary care practitioners amidst a strong uptake of this treatment modality by patients and the federal government's endorsement of telehealth in the GP setting even before COVID-19 restrictions were put in place (from July 2020 the policy was tightened to allow access in most cases only for providers who "have an existing and continuous relationship with a patient").

Just four months into the pandemic declaration more than three million Australian patients had received over 4.3 million health and medical services through the telehealth items introduced by the Australian Government for COVID-19.

A more recent survey of patient attitudes towards telehealth consultations showed almost 1-in-2 people are less likely to see their GP during the pandemic, with patients under 45 years being the keenest telehealth users. This cohort was far more likely than older patients to prefer telehealth to in-person appointments when restrictions are lifted.

The survey showed preferences for telehealth depend on the type of appointment, with those most in favour relating to results follow-ups and repeat script/referrals.

"For consultations with a new doctor, skin checks, and sick children, patients prefer in-person appointments," the survey reported.

Patients who have experienced telehealth are more likely to want to continue using it (68 percent 'somewhat or strongly agree' that they would prefer telehealth over in-person consultations beyond COVID-19). There is a general view – echoed in government circles – that telehealth will play an important role in general practice after COVID-19.

However, 1-in-3 patients harbour concerns about telehealth. Issues include internet limitations, the need for physical examination, logistics in getting scripts to pharmacies and privacy issues.

According to Debbie Elliott (*pictured above*), the practice manager of Lismore's long-standing Keen Street Clinic, the perceived risk of being exposed to the SARS-CoV-2 virus has alarmed a significant number of patients, especially the elderly, despite the vigilance exercised by practices across the region, and Australia-wide.

"Since the start of the pandemic we have been asking patients making appointments whether they have any of the commonly recognised symptoms, have travelled to 'hot spot' areas, or been in contact with any of those known cruise ship passengers."

In the rare cases that such risks have been confirmed, patients have been referred to the fever clinic at Lismore Base Hospital. On the day we spoke in early August five people seeking appointments reported having cold and flu symptoms but did not match the other criteria.

"Similarly, we've been triaging people on arrival, asking the relevant questions, and ensuring that they use hand sanitiser. There's no doubt the pandemic has had a significant impact on our workload, and on our work practices."

But Ms Elliott feels the greatest, and likely the longest lasting, impact on patients' interaction with GP practices is the way in which consultations are conducted.

Explaining that most patients saw 'telehealth' as meaning phone consultations, rather than meetings conducted by Zoom, FaceTime and the like, she said that in April the clinic conducted ten to fifteen telehealth consultations a day, compared to only five 'walk-ins'. At the time we spoke they were conducting an average of five telehealth consults per day.

"Patients were initially fearful of coming in for an appointment, which was understandable even though we assured them that all precautionary measures were in place. Now telehealth is becoming the new normal, and it's certainly easier for the elderly patients. They don't need to drive or get driven in, park, wait around, and so on.

"Also, pharmacies are able to deliver prescribed medications, which saves them a trip to the shops. While all this is more convenient, there are signs that patients who should be coming in to see doctors face-to-face are less inclined to do so, and this may have negative impacts on their health."

Ms Elliott mentioned a range of procedures that can only be conducted in person, including blood pressure and skin checks, PAP smears and breast screening, as well as mental health appointments where a degree of personal intimacy is often essential.

"As efficient as the new technology can be, and as people become more comfortable with it, the fact is that it can't be a substitute for face-to-face consultations across the board.

"I think the challenge is being taken up by GPs who will encourage patients to come back on the basis that 'we haven't seen you for a while'. Practice staff will support this by ensuring patients understand that we're not allowing 'sick', i.e. infectious, people into the building.

"While a telehealth consult is fine for a medication renewal or general advice, we mustn't see it as the norm, or people will fall through the cracks. The messages are clear – come and see your doctor when you need to, and if you're not sure when this is, please ask. Also, be assured that GP practices are safe places to visit as long as you follow the advice of the trained staff."

Comprehensive support program for oncology patients at John Flynn Hospital

Associate Prof Siddhartha Baxi
Radiation Oncologist/Regional Medical Director,
GenesisCare Gold Coast

"We design individualised cancer care and are proud of the expert allied health care team that supports patients through a very difficult time in their lives."

- A/Prof Siddhartha Baxi
  Regional Medical Director, Gold Coast

GenesisCare/Ramsay Health Plus oncology allied health team
A/Prof Sid Baxi (radiation oncologist), Jessica Singh (speech therapist)
Victoria Renton (dietitian) Emily Ballarin (oncology nurse)

GenesisCare, in partnership with Ramsay Health Plus at John Flynn Hospital, has created a comprehensive allied health care program for patients undergoing radiation therapy or stereotactic radiotherapy. Australian expert bodies. such as Cancer Australia, advocate that optimal cancer care pathways require key allied health practitioners to support patients throughout their treatment, for example with head and neck cancer [1].

Likewise, position statements from the Clinical Oncology Society of Australia (COSA) support the need for allied heath involvement, with evidence indicating patients can benefit from improved nutrition, mental and physical well-being and improved recovery from treatment [2].

Tara Quinn
Occupational therapist

We aim for best practice cancer care for patients by offering:
- dietetics: to optimise nutritional support
- speech pathology: to assess and optimise safe swallowing, speech and oral function
- occupational therapy: management of the physiological effects of cancer treatment
- lymphoedema therapy: prevention and management strategies
- expert oncology nursing care: to support recovery and skin care management during and after treatment

We understand that collaboration is key with community cancer care advocacy groups such as the Cancer Council and providing patients with links to relevant groups that will help deliver the support required throughout their cancer journey.

"At GenesisCare, we strive to do our life's best work for our patients and community."
- Emily Ballarin (nurse manager)

Contact: GenesisCare Tugun (07) 5507 3600 **receptiononcologytugun@genesiscare.com**
Website: **https://www.genesiscare.com/au/**
Cost: Consultations with the allied health team are included as part of our personalised radiation therapy treatment program.

GenesisCare

1. **https://www.cancer.org.au/assets/pdf/head-and-neck-cancers-optimal-cancer-care-pathway**
2. **https://wiki.cancer.org.au/australia/COSA:Head_and_neck_cancer_nutrition_guidelines**

Doctor with disability 'shocked' by negativity

A resident medical officer at the Gold Coast University Hospital is encouraging people with disability to share their story with the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Dr Dinesh Palipana OAM (*picture right*) uses a wheelchair after sustaining a spinal cord injury in a traumatic car accident in 2010. He was the first quadriplegic medical intern in Queensland, and the second person in Australia to graduate from medical school with quadriplegia.

The 35-year-old is now an RMO at the Gold Coast University Hospital, a lecturer at Griffith University and adjunct research fellow at the Menzies Health Institute of Queensland. Dr Palipana, who also holds a law degree, recently told **ABC News** that after his injury, he was shocked to discover such negative attitudes towards people with disability.

Dr Palipana included some of his experiences in his submission to the Royal Commission and is urging others to share their stories. This can be submitted through **the Commission's website**, over the phone, in a video or audio recording or by making a submission, including in a private session with a Commissioner, and in a preferred language, including Indigenous languages and Auslan. The Commission can provide interpreters and translators.

"Unless we speak out nothing will change. If you tell your story there's nothing to be scared of because you're speaking the truth," he told ABC.

As a result of his experiences, Dr Palipana has become an advocate for inclusivity and a tireless advocate for medical students with disability. He is also the founding member of Doctors with Disabilities Australia, an ambassador for Physical Disability Australia and – when you want something done, ask a busy person - a doctor for the Gold Coast Titans physical disability rugby team.

(Thanks to the Royal Commission's newsletter Connect for input to this story).

End "panic and neglect funding", Virology Society urges

In an impassioned plea aimed at ensuring Australia avoids the emergence of the "next Disease X pandemic", the high-profile Australasian Virology Society has called for an end to the "panic and neglect cycle of funding" that it says has characterised the nation's past response to health crises.

It has also called for a boost in medical research to three per cent of health expenditure, adding that what is "often termed discovery research" is the "engine of innovation without which our clinicians and public health researchers would not have the diagnostic, vaccine and antiviral tools needed to combat infectious diseases."

Noting the widespread impact of the COVID-19 pandemic the Society said the next pandemic may be worse and may have more efficient human-to-human spread.

"While predicting the timing of the next pandemic is impossible, there is no aspect to its response, including surveillance, detection, diagnosis, treatment, epidemiology, antivirals and vaccines, that would not be improved by investing in basic research," according to the signatories of the statement of 12 June 2020.

They warned, "We do not know what virus will cause the next pandemic, with the only certainty being its inevitability."

There is also a strong financial argument, with a 2018 report by the Association of Australian Medical Research Institutes finding that for every $1 invested in medical research, $3.90 is returned to the broader economy in the form of both community health benefits and direct returns from commercialisation.

"In a pandemic response this multiplier may be dramatically higher," the Society added.

"Yet development of effective prophylactics and treatments takes years, requiring appropriate biocontainment facilities across the country, sustained funding and a trained workforce.

"Between 2012 and 2017 the NHMRC full-time workforce decreased by 20%, reducing our capability to respond to COVID-19. This has resulted in the failure to keep biocontainment facilities in service at several academic institutions, meaning that some suitably trained virologists cannot even begin research with a new virus.

"While new funds targeting COVID-19 and CSIRO-ACDP labs in Geelong are welcome, in future there must be continued expansion and development of Australia's basic research capability in all disciplines, but especially infection and immunity."

The Australasian Virology Society represents over 700 members who include prominent researchers, clinicians and scientists working with viral infectious diseases and the means for their management and prevention.

Black rice a top dish on research menu

Some people call it a "superfood", others enjoy it as a somewhat unusual pudding you eat on holidays in Bali. Now black rice is the focus of a $600,000 Australian Research Council (ARC) grant to Southern Cross University (SCU) to determine what drives its nutritional quality.

Plant Science Associate Professor Tobias Kretzschmar is leading a research team aimed at improving breeding of quality cultivars that can exploit the growing environments of subtropical and northern Australian and enable domestic production of high-value, healthy black rice.

"The demand for functional foods with health benefits, including black rice, is increasing both domestically and internationally," Assoc Prof Kretzschmar said.

"While high UV levels in Australia are often viewed as a negative climatic

Associate Professor Tobias Kretzschmar of Southern Cross University with a black rice diversity panel growing in the polytunnel facility at NSW DPI Wollongbar.

- a Southern Cross University research project

factor, this radiation may actually have an advantage in boosting the accumulation of healthy compounds in optimised black rice, making Australia – and specifically the NSW Northern Rivers – well placed to produce the highest quality black rice."

Black rice's distinctive dark colour comes from a range of naturally occurring compounds called 'anthocyanins', known to be beneficial agents in reducing inflammation. It also has major antioxidant properties that have the potential to reduce the glycaemic index of rice.

Assoc Prof Kretzschmar, who joined SCU two years ago, has worked with rice for more than 10 years, including at the International Rice Research Institute genebank in the Philippines which houses more than 100,000 types of rice.

The black rice project involved identifying 300 lines from a collection that originates from 19 countries across Asia and Africa. For the first time these black rice lines will be grown in Australia, with the backing of the ARC Linkage program.

"This project will pave the way for the development of a profitable crop alternative for farmers in the subtropics and northern Australia," Assoc Prof Kretzschmar said.

"In the long term this has the potential to improve farm income and increase the financial sustainability of farming businesses, while also creating supply chains in processing and packaging in regional and remote areas

Australia's southern Riverina region already produces high quality rice. However, the pigmented rice is a niche crop with growth potential in domestic and international markets.

"The project will also provide critical genetic and nutritional information for future breeding of high-value 'healthy' rice to help meet the national targets of improving the health of Australians," said Associate Professor Kretzschmar.

Lismore's COVID-19 testing passes 20,000 milestone

In late July NSW Health Pathology's Lismore laboratory geared up for any possible upsurge in demand for COVID-19 testing, having already exceeded 20,000 tests on patient samples collected at public hospitals and mobile clinics between Tweed Heads and Grafton, and along the coast.

Glenn Hawkins, the lab's Manager of Microbiology, said, "Our laboratory is currently averaging around 300 diagnostic COVID-19 tests per day, however we have the capacity to test up to 400, if needed.

Lismore is part of NSW Health Pathology's network of 12 specialist laboratories across the state conducting COVID-19 diagnostic testing, around half of them are in regional areas.

"The availability of local COVID-19 testing in regional laboratories will deliver greater testing capacity and faster turnaround times for local communities," Mr Hawkins added.

"Fast, accurate testing enables early diagnosis and management of COVID-19 cases, which is vital for the protection of the community and to curb the spread of the virus. NSW Health Pathology's Lismore laboratory is also set up for rapid PCR testing, to be used for high-risk, high-priority cases where an urgent diagnosis is needed.

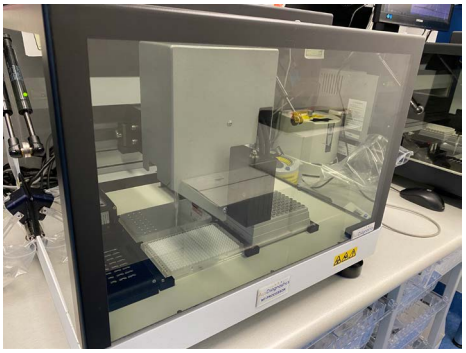
"These include the elderly, acutely unwell patients or those with pre-existing or chronic health conditions."

NSW has one of the highest COVID-19 testing rates in the world. A total of 1,218,155 tests have been done, and more than 350,000 registrations for their pioneering SMS Results Service that has halved the average waiting time for negative results.

"As restrictions ease gradually, it is crucial to come forward for testing, even if you only have minor symptoms, to ensure we keep community transmission at bay," Mr Hawkins said. "Anyone with flu-like symptoms, no matter how mild, should get tested. Common symptoms include cough, sore or scratch throat, shortness of breath or fever."

Stage 1 – Laboratory technician loading COVID-19 swab samples into sample tray.

Stage 2 – Instrument to extract the DNA from the sample for testing.



Stage 3 – DNA amplifying and detection robot – this is the diagnostic part of the test

Book Review

The Doctor Who Fooled the World

By Brian Deer
Scribe 394pp

This well argued and entertainingly written hatchet job says as much about journalism as it does about medicine, with both undertakings coming off badly at the hands of a writer with a distinguished record of investigating the healthcare and drug industries.

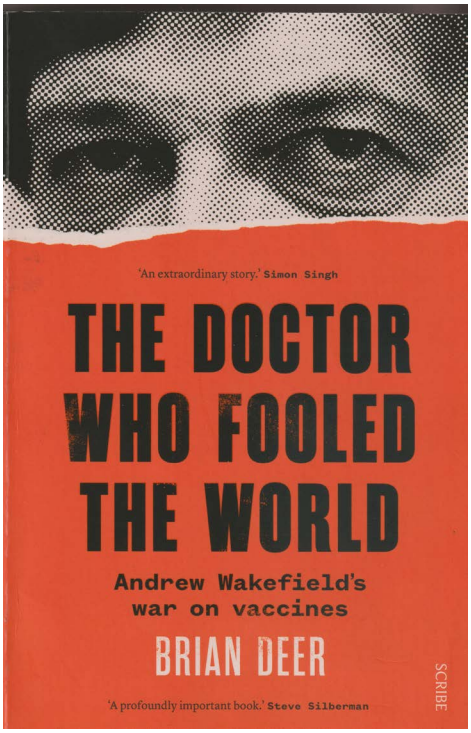
The central premise, how a charismatic individual could perpetrate a damaging con, is reminiscent of **last year's Bad Blood** about the blood testing 'breakthrough' developed by a disgraced Silicon Valley startup named Theranos.

That book's sub-title, "Secrets and Lies", applies in spades to this study of how the now-disgraced British doctor Andrew Wakefield - the son of doctor-parents, his father highly distinguished - could make the public believe that the MMR vaccination was, in a disturbing number of cases, linked to colitis and in short turn to autism.

This claim, based on compromised research, caused massive parental concern and led to a plunge in global vaccination rates. Even more astounding was how the charismatic (that word again) and self-promoting Wakefield could receive such support from key sections of the UK and, later the US, media, and senior lawyers.

Most concerning was the backing of many medical colleagues, sucked in, it seems, by his presentation: "He is tall, handsome, charismatic [!] and above all a man of conviction... utter sincerity and honesty," said an Australian colleague, John Walker-Smith, dubbed "more English than the English" by the author.

Fortunately, some were less gushing but alas not in time. Dr Mark Pepys, the red Jaguar driving, massively high-achieving head of Hampstead Hospital, would list twenty-five conditions for taking his new job. One of which was the immediate termination of Wakefield: "I knew he was a wanker and a fraud."



Such a view lay in the future in 1988 when the 32-year-old Dr Wakefield, a junior surgeon, arrived at London's Royal Free Hospital, a struggling institution, and soon began pondering the "undiscovered culprit" for Crohn's disease. This, he would decide, was measles, particularly for patients who had been immunised against it. A Wakefield-led team conducted a study, which would be published over three pages in The Lancet. Because they hedged some bets the journal added a question mark to the article's title: "Is measles vaccination a risk factor for inflammatory bowel disease?"

As Deer notes, this provoked some amusement, with the wording called an example of 'Hinchliffe's rule' - "If the title of a scholarly article is a yes-no question, the answer is 'no'.".

In journalism it is known as 'Betteridge's law of headlines'. As scribe Ian Betteridge wrote, "The reason why journalists use that style of headline is that they know the story is probably bullshit, and don't actually have the sources and facts to back it up, but still want to run it."

Clearly the bullshit detector was turned off at The Lancet at a time when the editor Richard Horton, a former medico, had recently assumed the role. Sadly, little seems to have changed since. When I began this book The Lancet had just retracted a published article about global trials of hydroxychloroquine for Covid-19 after a Guardian investigation found inconsistencies in data provided for the research by US company Surgisphere.

Exonerating the journal, and presumably himself, from any blame the "appalled" editor, the same Mr Horton, said, "This is a shocking example of research misconduct..."

He would hold the position throughout the Wakefield scandal and use it, wittingly or not, to promote the dodgy doctor's arguments, seemingly with the aim of furthering his journal's prestige as a medical news-breaker.

In 2004 Deer met with the "dapper" Horton, flanked by five staff, and confronted the journal with inconsistencies in the published Wakefield articles. His focus was that the small sample of parents blaming the three-in-one shot for their child's "developmental regression" had been privately encouraged to do so by Wakefield's legal team. The motive was that successful legal action could win them millions in compensation. Wakefield's take would be hefty consultancy fees.

Worse was the suffering inflicted on children who had been "forced through the hospital, some kicking and screaming, for the battery of sedations, scopings, scans, spinal taps, blood draws, and barium drinks."

Noting Horton was "struggling to suppress a reaction", Deer adds, "Not only was he a medical practitioner, but for years he'd virtue-signalled on such matters... He was Dr. Squeaky Clean on propriety."

As their five-hour meeting progressed - sandwiches for lunch - his colleagues from The Sunday Times were across town meeting with Wakefield himself, just returned from Austin, Texas for an interview that Deer was barred from attending: "He saw a chance to work his charisma on journalists who lacked my

by Robin Osborne

grasp of the facts."

Wakefield was hammered, the "killer issue" being the ethics of his working secretly with lawyers for the parents of children whose genuine deficits, including autism, could not be attributed to the MMR vaccine.

When asked if the link should have been disclosed, Wakefield disagreed.

"And there he was, Rules didn't apply to him. Not even rules to protect the integrity of potentially life-impacting medical research... I acted with due propriety in every case, I have no regrets."

When the Times front-paged the story (Revealed: MMR research scandal) Wakefield's colleagues ran a mile (Docs dramatic U-turn), as did Wakefield – back to the USA where the tabloid media continued to fete him. Appropriately, he attended the inauguration ball of the dissembling new president, Donald J Trump, who would accuse CDC doctors of covering up the supposed links between MMR and autism.

Not to be upstaged, Wakefield live-streamed himself from the event on a self-broadcasting app: "Very exciting times, I wish you could all be here with us."

Me too, remarks the author.

The disgraced-doctor would remain in the US, going on to widen his opposition to vaccinations and making the notorious documentary Vaxxed, while having a relationship with Australian supermodel Elle Macpherson for whom his charisma apparently held more appeal than his honesty.

Like a vampire awaiting a wooden stake through the heart, Wakefield soldiers on, and his reach extends to Australia. It was reported (The Sun-Herald 14 June 2020) that his film and a follow-up, Vaxxed II: The People's Truth, would be screened on a 'mobile billboard' bus travelling the nation on behalf of the Australian Vaccination-risks Network', which cranked up its efforts during the height of the COVID-19 scare.

In late May medical experts said decades of progress on vaccination education could be undone, and called for an urgent vaccine campaign. In the current context, this book could not be timelier.

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Dr Sarah McGahan MBBS FRCPA
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(02) 6620 1203

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

Dr Andrew Mayer MBBS(Hons) FRCPA
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(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. Dr van der Hoeven joined SNP in 2019.

www.snp.com.au

CAPE Institute covers Clinical And Practice Education

On 1 July 2020, North Coast General Practice Training (NCGPT) launched CAPE Institute, continuing to deliver quality education for clinicians but now expanded to include practice teams as well. CAPE's systems simplify tracking education and training records, a new burden for health professionals, now necessary under AHPRA's updated CPD requirements.

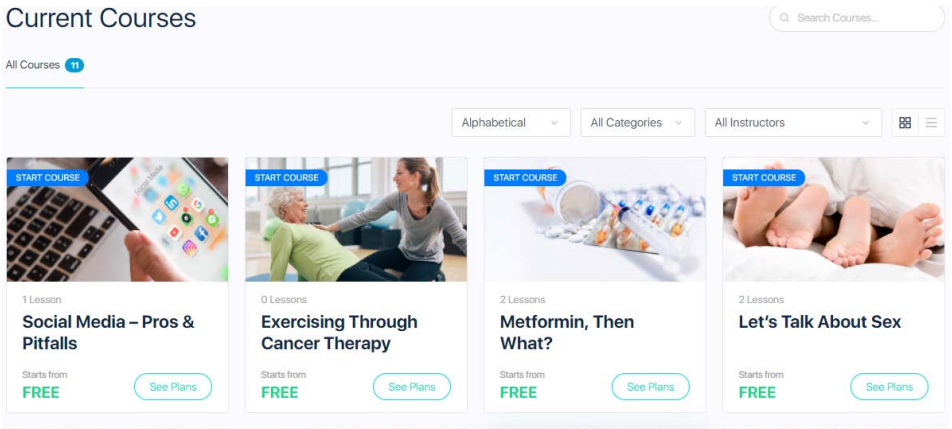
NCGPT was known as a not-for-profit organisation that has always had quality general practice at its heart. NCGPT was faced with the prospect of operating without a grant from a major funder, following an unexpected decision from the Primary Health Network to establish an in-house team to develop and deliver clinical education in their catchment. This role was previously undertaken by NCGPT on their behalf.

The Board of NCGPT has been encouraged by feedback from clinicians in the region and had already been considering strategies to build a sustainable future. After talking to local clinicians we realised there was a significant appetite for affordable, reliable, unbiased, independent education.

GPs, Nurses and Allied Health Professionals reported unmet education needs and expressed frustration about the cost and inconvenience of meeting their CPD requirements. GPs felt 'swamped' with education about national priorities and COVID-19, but said it was harder to find independent, practical and sponsor free education that was relevant to regional general practice.

Nurses experienced many barriers to obtaining education relevant to general practice settings, while Allied Health professionals reported that while they could access discipline specific education from their professional associations, many areas of interest that involved interprofessional practice were unmet.

Practice managers and owners were vocal about the challenges they faced relating to sourcing appropriate training for clinical and non-clinical staff to meet accreditation and registration standards. They expressed frustration about the time wasted sourcing and tracking professional development for multiple staff, particularly when provided by a myriad of organisations.



A number of GPs and Allied Health Professionals also highlighted the need for business skills training identified in the NSW Rural Doctors Network Primary Health Workforce Needs Assessment 2019-20. Although not traditionally taught to health professionals, many clinicians in regional Australia find themselves as owners of independent, dynamic businesses and responsible for large numbers of staff - unsurprisingly there is a demand.

Research into the cost of education highlighted the variability across providers of CPD. Face-to-face education had added costs related to disrupted practice operations and travel. Some 'free' education was available only to limited audiences based on geography or was provided to customers of a particular vendor. Much digital education was designed as modules for self-paced learning and was not regularly refreshed.

The CAPE Institute program has been designed to provide simple access to affordable, quality education with the needs of general practices and other health businesses in mind.

Topics are spread across three streams: Clinical, Management and Compliance, and Wellbeing. Alignment to RACGP accreditation standards is strong, with mandatory topics delivered across the year and clinical subjects incorporating key standards and including clinical discussion questions and suggestions for QI activities where relevant.

Subscriptions are available to suit individuals and practice teams of all sizes and provide predictability, removing the need for multiple transactions for individual events. Subscribers can attend an unlimited number of courses without paying anything extra and have access to an exclusive subscriber only library.

As part of any subscription, CAPE Institute manages the training records - making it easier for individuals and practices to track CPD for compliance reporting to AHPRA and accrediting agencies.

Given the recent changes to the APHRA declaration process for GPs there are potentially significant savings for those GPs who decide to record their own CPD rather than using the RACGP system. Once one takes into account that this is pre tax spending, the cost of subscriptions becomes very attractive. For those socially minded, NCGPT is a not-for-profit organisation, so any profits from ticket sales or subscriptions go back into education, rather than into the pocket of a corporation.

Sharyn White, CEO of NCGPT is confident that CAPE Institute will deliver quality education and have a range of interesting topics in the program.

"The pricing provides real value for money. NCGPT has a great reputation for working well with general practices and now we are launching a unique service that clinicians have long been saying is needed but somehow never gets addressed.

"It's time for general practices and allied health businesses to band together and get the service that they want - not what others dictate".

To learn more about CAPE's webinar series and to subscribe to their programs visit **www.CAPEinstitute.org.au**

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Medical

Aboriginal offenders' impairment mitigates against custody

A two-year-long neuropsychological project involving adult Aboriginal people in NSW charged with an offence has found that 72% had significant cognitive impairment, with almost 50% of cases being diverted from custody when these findings were submitted to court at the time of their sentencing.

ABS figures show Aboriginal and Torres Strait Islander people make up approximately 2% of the general population aged 18 and over but represent 28% of the prison population nationwide. Aboriginal and Torres Strait Islander people with mental health issues and cognitive disability are over-represented in their contact with all aspects of the criminal justice system.

The results of the Aboriginal Assessment Project (AAP) were shown to a Magistrate in the Lismore area who would subsequently see and sentence some of the 45 participants. The law officer said the project had a "profound effect" on him, noting, "What if the offender is not really bad, mad, addicted (although elements of these are regularly present) but instead has a cognitive age of five?

"Rehabilitation, retribution, specific and general deterrence, and even denunciation are put in a different context when confronted with such drastically low levels of cognitive ability.

"We don't lock up five-year-olds for obvious reasons, and it calls into question why we should lock up those with an equivalent mental age either. Of course I would like to see this project expanded outside this region, state and nationwide if possible.

"But more than that, we need a far more therapeutic setting to deal with these damaged people than the traditional court system. Just like we have Children's Courts and Drug Courts and Circle Sentencing we do not have specialised courts or approaches to deal with those who suffer from a profound intellectual disability other than discharging them into the mental health system. It is completely inadequate in my opinion."

The AAP was undertaken by two experienced neuropsychologists working pro bono, with travel expenses covered by the NSW Department of Communities and Justice. In the light of information gathered, around half of the participants were diverted from a custodial sentence.

Dr Robin Murray, Clinical Neuropsychologist (left) and Dr Molly Schafer, Clinical Neuropsychologist (right)

Results included: 72% had impaired intellectual functioning, 74% had impaired verbal comprehension skills, 74% of participants had reading skills at the Year 3 level, 97% of participants had mathematical skills at the Year 2 level and 88% of participants had an impaired adaptive functioning.

Upon release from prison such detainees often require support to lead an independent life in the community, including housing and employment services.

Many Aboriginal and Torres Strait Islander people have never had their disability formally diagnosed until they enter custody due to a lack of access to specialists for diagnosis, lack of recognition of the diagnosis or a hesitancy to be diagnosed and labelled with a disability due to cultural bias," the report states.

"Assessments could provide evidence of cognitive impairment, such as an intellectual disability, acquired brain injury (ABI) or Foetal Alcohol Spectrum Disorder (FASD). Without an assessment, there was an increased likelihood that a person would be given a custodial sentence."

It adds, "Many Aboriginal people appearing at local court with cognitive impairment are often unemployed, have difficulty accessing support and rarely have the financial resources to pay for an assessment. Additionally, there is a paucity of neuropsychologists in rural areas.

"Often those with cognitive impairment find themselves in front of court for minor offences and they have difficulty comprehending the implications of their actions. Reduced understanding of the consequences of their actions can lead to recidivism and a continuing cycle of serving custodial sentences.

"By conducting neuropsychological assessments, we hoped to reduce the number of people being sentenced to a custodial term and hence reduce the number of Aboriginal and Torres Strait Islander people in custody."

Some 96% of participants self-reported a history of alcohol and/or other drug (AOD) abuse, 38% reported that their parents had a history of AOD abuse, 7% were homeless and 40% of participants reported no history of paid employment.

Like the Lismore magistrate the project's authors recommend rolling out the AAP program to rural and remote areas across NSW, stating, "In the long-term, neuropsychologists, similarly to medical doctors, should be encouraged to practice in rural areas. A rural stint should form part of the requirement when enrolling in publicly funding neuropsychological education programs in Sydney metropolitan areas."

For a copy of the research paper, contact Dr Molly Schafer directly by email **mclarkschafer@gmail.com**

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ANNOUNCING NEW DIAGNOSTIC SERVICES

- Laboratory Sleep Studies
- Pulmonary Function Testing
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LABORATORY SLEEP STUDIES

Medisleep has reliably provided the Northern Rivers with home based sleep studies as its core service since 2011. In response to local and regional demand we are pleased to announce the expansion of our Ballina based sleep study service to now include fully monitored overnight In Lab Sleep Studies.

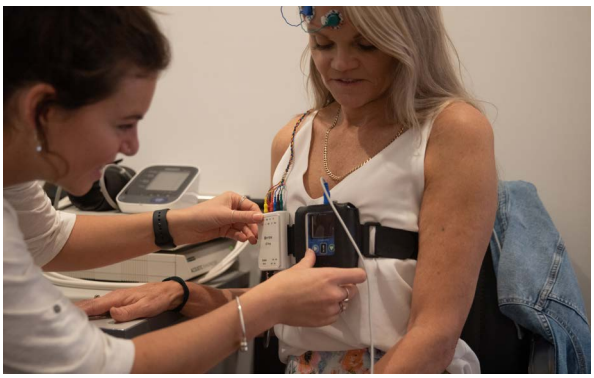
Our Ballina clinic has expanded for in-lab monitoring of up to 4 patients per night. Bookings are currently taken for Mondays and Tuesdays. A growing number of patients prefer an overnight in-lab sleep study for reasons such as inconvenient travel. Some elderly patients and those with a disability may find it easier than managing in-home monitoring devices. For other patients it may be the preference of Dr Williams (our qualified Sleep Medicine Practitioner) that the patient be looked after in the lab.

PULMONARY FUNCTION TESTING

The installation and commissioning of Pulmonary Function Testing equipment at the Ballina Clinic is now completed and referrals are being taken. We offer physician reported Pulmonary Function Tests for diagnostic, COPD and Asthma assessment. This is a welcome addition to local diagnostic services.

CARDIAC HOLTER MONITORING

In partnership with Holter Interpretation Services we offer 24 Hour Cardiac Holter Monitors. We have sufficient Holter recorders that , except in unusual circumstances . your patients can be promptly connected the same day. Our Holters are reported by cardiologists Dr Suchitra Chandar, Dr Richard Cranswick and Dr Shruti Kapila.



Medisleep will continue to provide the Northern Rivers with home based sleep studies and therapy including CPAP from all of the major suppliers including ResMed, Philips and Fisher and Paykel. This includes full support for DVA patients as a registered DVA provider in partnership with ResMed.

Vale Reverend Dorothy Gordon (née Roberts)

Goori Country

"Aunty Dorrie" passed away at Lismore Base Hospital on Friday August 7, 2020 at age 78 years. She grew up in the toughest of circumstances at Cubawee, an Aboriginal mission near Lismore, and went on to become the first ordained Aboriginal minister in NSW, working extensively, and tirelessly, as a prison chaplain in many settings, including Sydney's Long Bay jail.

Loving reminiscences of Aunty Dorrie's life were shared recently with ABC Radio's North Coast audience by her granddaughter, the well-known arts identity Rhoda Roberts. The words 'humility' and 'nurturing' perhaps best summarised the Elder's personal characteristics

Our thoughts and sympathy go out to Aunty Dorrie's family members and the wider Bundjalung community. A true icon of North Coast culture may have departed this life but she will be long remembered.

The photo of Aunty Dorrie Gordon (right), taken by Kate Holmes, is one of the images in the book Our Way Stories, published by Arts Northern Rivers .

Attorneys fail kids on imprisonment

OPINION

by Andrew Binns

'Right now, Australian children as young as 10 years old can be arrested by police, hauled before a court and sent to youth prisons' decries the **Raise The Age** organisation.

That's why the 'Keep Kids in the Community' coalition was calling on governments to raise the age of criminal responsibility from 10 to 14 years, bringing us into line with other countries. The European average is 14 years.

All the medical evidence tells us that children's brains are still developing at this age, and early contact with the criminal legal system can cause lifelong harm. Many suffer from cognitive impairment, which has various causes, including foetal alcohol syndrome. Other reasons cited for this change are protection of children's rights and the limited ability of doli incapax (of 10-14 year olds not knowing their behaviour is wrong, rather than just being mischievous).

In 1998 the Australian Government abolished the principle of doli incapax. The Council of Attorneys-General, consisting of law makers from states, territories and the Commonwealth, had agreed in 2018 it would be appropriate to consider raising the age from 10 to 14 years.

However, in late July 2020, when they met again to discuss the issue, they voted to delay for another year a decision on raising the age of criminal responsibility. According to the Australian Institute of Health and Welfare there were almost 600 children aged 10 to 13 in detention in Australia last financial year. More than 60 per cent were Aboriginal or Torres Strait Islander children.

NSW Attorney-General Mark Speakman said (SMH July 27, 2020) there were currently 200 young people in NSW youth justice centres, down by a third from five years ago. The youngest offenders in the NSW corrections system were three offenders aged 13.

He expected a decision, one way or another, next year: "Community safety is the most important criteria in all of this... there is a considerable amount of evidence that the best way to treat young offenders is therapeutically to avoid reoffending."

Reasons for delaying the decision included the need to develop therapeutic strategies, social support and educational programs to facilitate the proposed change. One can only hope these issues will be addressed before the next meeting of the Council in 2021. Meanwhile, community pressure and campaigns need to keep going.

*On 20 August it was reported that the ACT had become the first Australian jurisdiction to agree to raise the age of criminal responsibility from 10 to 14 years, in line with UN standards. The resolution by the Legislative Assembly makes it the responsibility of the government that wins the upcoming election in October to consider the legislation.

Artwork by Chips Mackinolty, long regarded as one of Australia's most accomplished political poster artists. A one-hour interview with Chips about his extraordinary life and work has recently been posted online at Episode #6 – Chips Mackinolty – A LIMINAL SPACE http://www.aliminalspace.earth/episode-6-chips-mackinolty/

Immunotherapy in Oncology/Haematology

by Dr Benjamin Watson,
Advanced Trainee in Medical Oncology and General Medicine

Oncology and haematology are currently experiencing a significant shift in therapeutics, with more novel agents being produced and immunotherapy being approved for a greater range of malignancies and circumstances. Even for specialists in the field, keeping up to date with the latest agents, their use and their side effect profile is challenging.

Immunotherapy

The importance of the interaction between a tumour cell population and the immune system is currently being studied extensively, with notable inroads into changing the balance in favour of the patient.

Immune mediated cell death can occur at the site of the cancer when Natural Killer, T and B cells recognise abnormal antigens expressed on the surface or released by a cancer cell. Mediated through cytokines, including IL2 (interleukin 2), the interferons IFNα and IFNγ, these immune cells cause immediate cell death, forming part of the innate immune response. The adaptive immune response is far more effective and specific: Antigen Presenting Cells (APC) migrate to regional lymph nodes, present cancer antigens using the interactions between MHC-T Cell Receptors and CD28-CD7 costimulatory molecules, thereby initiating a population of T cells that are specific against the cancer cells. These T cells recognise any cell expressing the specific antigen leading to cytotoxic cell death. Cancer cells can evade this immune mediated cell death by:

- Reducing their expression of abnormal/ cancer antigens
- Inhibiting APC activation of T cells by reducing the CD28-CD7 interaction, CTLA4 is expressed on T cells and inhibits the activation
- Blocking cytotoxic cell death by expressing Programmed Death Ligand 1 (PDL1), effectively telling the immune system "I am a normal cell"
- Excluding immune cells from the tumour site
- Increasing cytokines IL10 and transforming growth factor beta (TGFβ) and T regulatory cells, which suppress the immune system

Immunotherapy includes several different therapies, each with different mechanisms including checkpoint inhibitors, cytokines, chimeric T cells and vaccines. Nowadays, **checkpoint inhibitors** are the most used, which the following discussion will focus on.

1. **Mechanism of Action** – PDL1 can be inhibited by monoclonal antibodies either targeting PDL1 on cancer cells or by targeting PD1 on T cells. This inhibition allows the cytotoxic T cell to destroy the cancer at the site of the tumour. PDL1 inhibitors include Pembrolizumab and Nivolumab. PD1 inhibitors include Atezolizumab, Avelumab and Durvalumab.

CTLA4 can also be inhibited by specific monoclonal antibodies, leading to the activation of T cells at lymph nodes, which can then specifically target the cancer cells. Ipilumumab is currently the only approved.

2. **Efficacy example** – the above agents became famous when single agents combining Ipilimumab and Nivolumab were used for metastatic melanoma with response rates of 68.1%, compared to 8-10%, for the previous standard of care, chemotherapy. The median overall survival for patients with metastatic melanoma has increased from 10.8 months to 37.5 months since these landmark trials: CHECKMATE 066, 067 and KEYNOTE 006.

3. **Metastatic setting** – Combined immunotherapy with CTLA4 and PD1 inhibitors is approved for metastatic melanoma and high-risk renal cell carcinoma. Single agent PD1 inhibitors can be used first line for metastatic melanoma, non-small cell lung cancer with high PDL1 expression, and as second line in squamous cell head and neck, hepatic cell carcinoma, cervical, renal cell, lung, bladder cancer and refractory Hodgkin lymphoma and primary mediastinal large B cell lymphoma.

4. **Adjuvant setting** – PDL1 inhibitor Durvalumab has been approved for stage III non-small cell lung cancer post chemoradiation (PACIFIC) and Nivolumab approved for completely resected stage IIIB-IV melanoma with a reduction in recurrence of 20% (CHECKMATE 238). Duration of therapy is 12 months.

5. **Combination with chemotherapy** – The addition of chemotherapy to immunotherapy increases response rates likely due to chemotherapy causing cytotoxic cell death, thereby increasing the tumours exposure to immune cells and releasing more cancer antigens. This combination is now approved in small cell and non-small cell lung cancer.

6. **New Evidence** – emerging studies have revealed a significant improvement in disease free survival using immunotherapy in combination with chemotherapy for triple negative breast cancer (KEYNOTE355), immunotherapy post chemotherapy for bladder cancer (JAVELIN Bladder 100) and immunotherapy instead of chemotherapy for microsatellite unstable (high mutation rate) colon cancer (KEYNOTE177). These are not yet approved by the PBS.

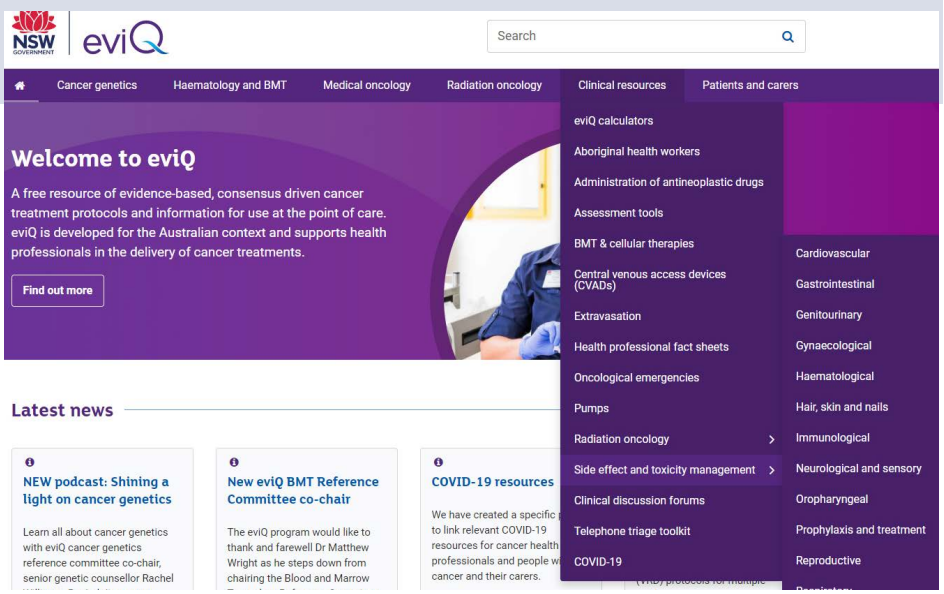
7. **Immune related adverse events** - irAEs are common and idiosyncratic. Each patient's immune system is unique and therefore each patient can develop different autoimmune sequlae when receiving immunotherapy. A history of significant autoimmune condition is a contraindication for immunotherapy.

Adverse effects include - fatigue (36%), rash (23%), diarrhoea (21%), hypothyroidism (11%), arthritis (10%), hepatitis (5%) and less commonly hypopituitarism, pneumonitis, myocarditis, meningitis and Guillain Barre Syndrome (GBS). The majority are mild, with immunotherapy better tolerated than traditional chemotherapy. However, the combination of two immunotherapy agents is associated with significantly higher discontinuation rates, with up to 50% being unable to complete the scheduled treatment.

Treatment of irAEs – mild events can be treated symptomatically (example – commence thyroid hormone replacement for hypothyroidism) and immunotherapy can be safely continued. Moderate events require steroids, generally 1mg/kg prednisolone and a treatment break. Severe events often require hospitalisation and intravenous steroids

such as methylprednisolone and the use of immunosuppressive agents including mycophenolate for hepatitis, infliximab for arthritis, IVIG for GBS.

8. **Resources** – the **NSW Health eviQ website** has a range of information for patients and professionals. Most treatment protocols are easily and freely accessible, explaining the schedule, administration, side effects and evidence. There is also a document "Management of immune-related adverse events (irAEs)" under the "Clinical Resources" tab.



Other Immunotherapies

Chimeric Antigen Receptor T (CAR-T) Cell Therapy – Patients with refractory DLBCL or B cell precursor acute lymphoblastic leukaemia have their T cells extracted and genetically modified in vitro. A gene is transduced into the T cells and encodes an anti-B cell chimeric antigen receptor. This cell line is duplicated and reinfused into the patient. Response rate has been very promising, however there is a high rate of cytokine release syndrome.

Bispecific T cell Engagers (BiTEs) - These are engineered antibodies with two variable fragments, one with specificity to T cells (CD3) and the other to a specific cancer antigen. The antibody therefore links a cytotoxic T cell to a cancer cell, theoretically resulting in cell death. Currently being studied in numerous haematological malignancies.

Cancer vaccination - Sipuleucel-T is approved in the USA for the treatment of metastatic prostate cancer. The patient's white blood cells are extracted from blood and exposed to a specific prostate antigen in the lab, supported to duplicate and then reinfused into the patient. There was a modest improvement in median survival.

Conclusion

Immunotherapy is an expensive but effective treatment in numerous malignancies, with emerging evidence changing standard of care on a regular basis. Compared to traditional chemotherapy, it has the capacity for a long-lasting response with better tolerance. Adverse effects are unpredictable, sometimes severe and require a high index of suspicion. Personalised medicine is being actively researched and antibodies engineered with therapies like CAR-T and BiTEs on the horizon. Indeed, times are exciting in oncology and haematology.

Ice Commissioner slams NSW Govt's response

by Robin Osborne

The lawyer heading the NSW Special Commission of Inquiry into the Drug 'Ice' penned a critical column in The Sydney Morning Herald (18 June 2020) urging the Berejiklian government to put politics aside and heed expert advice regarding the serious issues raised in his team's four-volume report (as reported in GPSpeak Autumn 2020).

Commissioner Dan Howard SC pointed to remarks made by Premier Berejiklian in 2018 when she announced the Inquiry: "I think, more and more, governments need to rely on experts, not on the politics but on the experts who provide us with the advice on what needs to happen."

The Commission conducted hearings in metro and regional locations, including Lismore, and took many submissions. The impact on Aboriginal communities was a key focus. After a long delay in releasing the report the government accepted some of the 108 recommendations, rejected others and left some awaiting comment at a later time.

Nine months have now passed, with no further responses forthcoming.

Among the rejections were the advice to open more medically supervised injecting centres, run needle and syringe programs in prisons, allow consumer substance testing (a.k.a. pill testing), notably at music festivals, and end the use of drug detection dogs.

Commissioner Howard wrote, "The commission also heard deeply moving insights from Aboriginal people throughout NSW about the harms that ice and other drugs continue to cause Indigenous Australians, and well-informed suggestions on ways to address this problem in their communities.

"The report acknowledges how colonisation and dispossession, and ongoing racism, family separations and intergenerational trauma endured by Indigenous Australians, have contributed significantly to the devastation that drugs have brought upon many of their communities.

"The NSW government perfunctorily rejected, without any meaningful analysis or discussion, five key recommendations... those other matters – including the Ice inquiry's detailed recommendations, and their relevance to Indigenous Australians – must be given proper attention, and lead to effective action."

Surf's up, along with the skin cancer rate

Researchers at Southern Cross University have launched an Australian-first study to determine the rates and types of skin cancers among surfers, swimmers and stand up paddle boarders (SUPs). The study, a joint initiative with John Flynn Hospital on the Gold Coast, is offering free skin checks at locations in Tugun and Mullumbimby to year-round water lovers aged 18 years and over.

Participants in the study will be asked to complete a research questionnaire, according to project leader Dr Mike Climstein, senior lecturer in Clinical Exercise Physiology at SCU's Gold Coast campus.

In 2016 Dr Climstein conducted an online self-reporting study that found the rate of melanomas among surfers was up to three times higher than the rest of the Australian general population.

"This latest research will lead to a more accurate snapshot by conducting specialist skin checks which in turn will lead to a more accurate determination of the prevalence and types of skin cancers - rather than relying on people's memory," Dr Climstein said.

Project leader Dr Mike Climstein has already found surfers experience three times the melanoma rate of Australians generally.

"Last time with the online survey a number of participants reported skin cancer but they couldn't remember what type it was, be it basal cell carcinoma, squamous cell carcinoma or melanoma, which underestimates the true prevalence of skin cancers," he said.

"This time we've got Honours student Brendan Doyle and a number of specialists and surgeons involved in the initiative, where the skin check and questionnaire go together. They are doing this at no cost to participants as long as they are regular surfers, swimmers and SUPs, so price is not a barrier to getting involved.

"We will also determine which prevention strategies are most effective based on the answers of those who have no history of sun cancer.

SCU 'over the Moon' about wound repair success

Researchers from Southern Cross University have developed a wound repair technique they believe has the ability to speed up the healing process and do away with the need for stitches, staples or glue in many clinical situations.

According to the research team the Rapid Repair novel wound dressing changes the way molecules repair, enabling faster and less interventional healing to take place. Pending expanded clinical trials with the University of Queensland, the technique has already received acclaim from NASA, winning the team its round in the US space program's "Ignite the Night iTech Event" and securing a place in the August semi-finals.

According to project leader Dr Rosemary Craig, a GP at SCU's Lismore campus Health Clinic, "NASA is already planning for the future, including the 'Moon to Mars' mission and hosts this competition series to hear about latest scientific advances and innovative space ideas.

"The panel of NASA scientists said they thought our rapid healing product would be very useful and valuable in space, especially as communication back to earth can often have a 10-minute delay and this is such a simple treatment to apply.

"We really are over the moon to win this part of the competition... the quality of the other innovations was extremely high."

The idea came to Dr Craig while she was recovering from a surgical procedure. She developed a device that appeared to heal full thickness skin cuts in a much shorter timeframe than normal.

Her team, which includes biomedical researcher Dr Nedeljka Rosic and business consultant Gerard Criss, has developed the commercial potential of the product through successes in CSIRO's ON Accelerate program.

Dr Rosemary Craig - photo : Southern Cross University

Dr Craig said, "During our clinical trial on skin cancer wounds we were able to remove patients' stitches after just one day. These trials are showing this novel dressing works on all skin types, including on aged skin and people with diabetes, and can minimise scarring.

"Future trials plan to heal cuts and wounds without using stitches at all.

"It is simple and painless to apply, using a non-invasive device with a long shelf life. The potential impact of this technology is enormous as it not only increases the rate of repair but significantly changes the way wound healing is understood."

While the team was unable to travel to San Francisco due to current restrictions, they were able to take part in NASA coaching sessions and give a series of virtual presentations and interviews across the week, mostly between 2am and 6am Australian time. Of the 25 semi-finalists, 10 teams will be chosen to spend a week at NASA when restrictions lift.

SCU said the Rapid Repair wound dressing is already entered on the Australian Register of Therapeutic Goods (ARTG 331993) and with a greater dataset will soon be able to register with the FDA.

The Head of its School of Health and Human Sciences, Professor Julie Jomeen, called the team's win an "amazing achievement" and said the school was excited to see the innovative research develop and deliver real impact in wound care.

Alcohol to get clearer pregnancy warnings – in three years

by Robin Osborne

By a narrow vote of 6-4, after nearly a decade of kicking the can (and the bottles) down the road, Australasia's food safety ministers have decreed that a prominent and direct warning of the risks of consuming alcohol during pregnancy must be placed on all alcohol products.

However, the requirement will not come into force until 2023, by which time many Australian women will have consumed alcohol during their pregnancy, unaware of the irreversible damage to their unborn babies from Foetal Alcohol Spectrum Disorder (FASD).

A notable opponent of the health measure, which is based on a long-standing recommendation of Food Standards Australia New Zealand, was the federal Food Minister Sen. Richard Colbeck (Libs, Tas) who chairs the ministerial forum that met on 17 July. A decision on the issue had been deferred from previous meetings, the main sticking point being the use, or not, of red ink to highlight the danger presented by alcohol to the unborn.

Advocates insisted red would make the warning more prominent than the current, barely visible symbol. Claiming to speak on behalf of all beer, wine and spirits purveyors the industry said printing red ink would come at an unbearable cost.

On behalf of the Commonwealth Sen. Colbeck proposed removing the red ink on the words 'Health Warning' and

Photo by Vitor Pinto on Unsplash

the do-not consume symbol. However, this did not seem to reflect federal government unanimity on the issue: Sophie Harrington, the COO of the National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD), a body funded by the Australian Government through the Department of Health, said, "Tens of thousands of Australian families who are impacted by FASD are celebrating today's decision, because they know how significantly this lifelong disability affects the health and wellbeing of our loved ones.

Supporting Sen. Colbeck's position were the governments of NSW, SA and Queensland. The other jurisdictions and NZ supported the upgraded warning.

An accepted amendment will see a change in the signal wording from 'HEALTH WARNING' to 'PREGNANCY WARNING'.

Sen Colbeck and others, as previously reported in GP Speak, had been lobbied intensively by the alcohol and beverages industry, which was "deeply disappointed" by the forum's decision, asserting that adding red to the labels would cost "hundreds of millions of dollars per year".

Such, of course, is the cost to the community – not to mention the personal distress to families – caused by FASD sufferers.

A counter lobbying effort came in the form of a full-page ad in The Sydney Morning Herald the day before the forum met, saying more than 3,700 community leaders and advocates and 150 organisations supported the revised labelling. These advocates included the AMA, RACP, Prof Fiona Stanley, Dame Quentin Bryce and Professor Elizabeth Elliott, the world renown researcher and advocate for FAS-D reform. (See GPSpeak article, **Getting Serious about the Social Determinants of Health**).

The Foundation for Education Research & Education's CEO Caterina Giorgi said, "Collectively, we genuinely thank the Food Ministers for implementing a warning that will benefit the community and reduce FASD.

"Having a red, black and white label is so important so the message can be understood by all Australians regardless of their literacy levels or cultural backgrounds."

NOFASD's Sophie Harrington said, "This new mandatory label will go a long way to improve community awareness of the risks of drinking alcohol throughout pregnancy and will result in fewer babies born with FASD in years to come."

New home for Rekindling the Spirit Health Service

by Andrew Binns

The development of Rekindling the Spirit Health Service dates back 17 years, its roots lying in what was called Gurgun Bulahnggelah (meaning "agree to walk together"), an Aboriginal health promotion service provided by Ellie Bradshaw and Teena Binge of the then-North Coast Area Health Service's Public Health Unit.

Since 1998, the premises had been occupied by the NSW Local Health District's Aboriginal Health Education Officers. It was suggested that some primary care health services were needed on the site as well, and I nominated myself and sought the assistance of GP colleagues Angela Bettess and Carol Stevenson. We commenced and provided the GP service linked to the Casino Aboriginal Medical Service (AMS) as an outreach service.

Sometime later there were changes which resulted in us relying exclusively on Medicare funding to maintain a rudimentary GP service. We asked for assistance from the Northern Rivers Division of General Practice (NRDGP), and were supported with an electronic medical record system and other resources, including staffing to support a more comprehensive GP service. We were also joined by some other allied health professionals, including a RN in 2008, and the service gradually expanded. We eventually became a service provided by NRDGP with some help from NSW Health.

Social distancing at RTS Health Service

Then came a name change to Jullums, Lismore Aboriginal Medical Service. The logo was based on an art work by Bundjalung artist Adrian Cameron, featuring four fish and symbolising people coming together for yarning around health matters.

Jullums partnered with Rekindling the Spirit (RTS), an Aboriginal counselling and support service founded by Greg Telford. They provided a culturally appropriate counselling service for us. When it came time for the North Coast Primary Health Network to hand over the service in 2017 to an Aboriginal controlled organisation, the successful amalgamation chosen was with RTS. The service continued to expand.

Initially our service was in an art deco style house opposite Lismore Base Hospital, charming but requiring a number of refurbishments. By 2020 it was bursting at the seams, with an increasing number of staff and health service providers. The RTS CEO, Georgina Cohen, with support from her Board, found a suitable medical facility nearby in Uralba Street, still close to the Base.

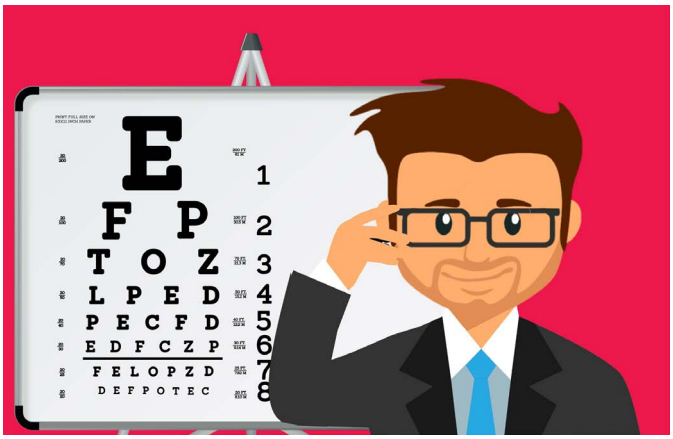
After three months of major refurbishment the big move took place in late-July 2020. The property is spacious, with a lot more consulting rooms for the expanding services. It is early days yet, but there is good feedback already from both the health providers and patients attending. The parking situation is much better and the number of health providers has already increased. Since the move the service has changed its name to the Rekindling the Spirit Health Service. It is located at 92 Uralba Street, Lismore, NSW.

Transport NSW gets rolling on IT

by David Guest

When it comes to IT, government departments are sleeping giants. They rarely move but when they do they take gargantuan leaps.

In December 2019 **Transport for New South Wales** (TfNSW) took over the running of the **Roads & Maritime Service** (RMS) and hence the issuance of commercial and private drivers' licenses.



The RMS had been gradually rolling out digital licenses since 2017 as part of its drive to increased efficiency, and this continues under TfNSW. Applications for a **digital driver's license** are accessed through the Service NSW website.

In a similar drive for increased proficiency TfNSW is also encouraging the renewal or upgrade of licenses through their online service. As a "web service" the renewal can be done any time and at any place. In practice this means it is usually done after hours at home. This is more convenient and efficient, and is encouraged in the era of social distancing under COVID-19.

The eligibility requirements to renew are the standard medical and vision criteria familiar to GPs doing driver medical examinations. The applicant also needs to have a signature and photograph on file with TfNSW that is less than 10.5 years old. In practice this allows for two five year renewals before fronting a Service NSW centre.

TfNSW has also been working on making the medical and eyesight examinations more efficient by providing a digital pathway for doctors. It has partnered with the electronic messaging provider **Healthlink** to allow medical practitioners to complete their **Fitness to Drive** forms online.

This facility has been embraced by many general practices as it allows an individualised form for each patient to be downloaded from the TfNSW systems. Patient demographics are taken from the practitioner's computer system and previous medical conditions from TfNSW's. This helps ensure accurate information while keeping key entry for the GP to a minimum.

The software prevents submission of the form if there is incomplete data. It also acknowledges successful registration of the application. A copy is kept on the GP's computer as well as on file with TfNSW and a paper copy can also be given to the patient for their records. The system has proven very popular with patients and medical practices alike.

One problem yet to be addressed is the documentation of eyesight status. Any abnormalities outside TfNSW's acceptable limits need review by an optometrist or ophthalmologist. Currently this service is unavailable in the Richmond Valley and the GP has to complete the paper form before the patient takes it to a Service NSW centre for registering.

Some of the larger optometry chains are gearing up to lodge their assessments online. When this happens it will be a happy day for patients, GPs and TfNSW.

COVID-19 vaccination wars could impact our health

OPINION

by Robin Osborne

In the lead-up to the American election the wearing (or not wearing) of masks has come to symbolise allegiance to political parties. Mask wearers are said to be Democrat supporters, while opponents, on the basis of 'civil liberties', are suggested to be Republicans, or at least right-wingers of a party that continues to support President Trump, despite the administration's gross mishandling of the COVID-19 pandemic (moving towards 200,000 deaths at the time of writing).

Despite the behaviour gap there has been the shared belief that when a proven COVID-19 vaccine is ready for rollout we can put away the masks and the hand sanitiser, and get ready to resume business and social life as usual.

That may be the hope, but as the head of WHO, Dr Tedros Adhanom Ghebreyesus (pictured right), said in late August, a COVID-19 vaccine will not be "a silver bullet", and the world should expect the coronavirus to be with us until 2022. On the upside, he added, this would be a shorter life than what was experienced with the devastating (and misnamed) Spanish flu.

Dr Tedros Adhanom Ghebreyesus
MONUSCO Photos (Crop)/ CC BY-SA

Of course, this is all in the future, so let us focus on the here and now, even if this seems to change on almost a daily basis. Amidst the global race to develop a vaccine – with Russia, ever hopeful for public relations credits, claiming a doubtful victory

COVID-19 vax – the news we're all awaiting

by Alannah Mann,
Alstonville Pharmacist

There has been much discussion around the development of a vaccination for COVID-19, making for a fascinating area of research. Typically, vaccination development takes around 10-20 years, but vaccine development for COVID-19 is occurring at a rapid pace and is featured almost daily in the news.

We are fortunate that advances in technology have been able to contribute to the speed of COVID-19 vaccine development, for example, we have already rapidly sequenced the SARS-CoV-2 genome. To develop a COVID-19 vaccine, most researchers have been investigating the spike proteins which allow the virus to attach and replicate. The spike proteins also generate a strong neutralising antibody immune response in humans – an effect important for vaccination efficacy. A strong T cell immune response is also associated with the spike protein and this may be another avenue for vaccination development.

One of the new technologies being investigated for a COVID-19 vaccine is nucleic acid vaccinations. This involves vaccinating the host with the spike protein's genetic material (RNA or DNA) that encode the antigen. Once administered, the host then creates the antigens, and this stimulates an immune response.

Although nucleic acid vaccination technologies are cost effective compared to other vaccine technologies, it is a new vaccine technology that appears to have issues with its stability and has not been licensed for use in humans before.

Other technologies for COVID-19 vaccinations include viral vectors whereby the spike protein is administered to the host using a harmless animal or human virus, such as adenovirus or poxviruses. There are also other viral vaccine development technologies already available for use, such as inactivated virus (used in whooping cough vaccine) and proteins (used in Gardasil 9®).

As of May this year, ten COVID-19 vaccines were undergoing phase I and II clinical trials, with many more vaccines (some of which are Australian) still being researched or in preclinical trials. Of the ten trials: four are using viral technology, four are using nucleic acid technology and two are using inactivated viruses (one of these with an alum adjuvant).

It must be acknowledged that there are challenges with regards to development of a COVID-19 vaccine: this vaccine might possibly exacerbate disease, COVID-19 may mutate over time, and patients may have a poor response to vaccines due to circulating neutralising antibodies from previous coronavirus infections (e.g. common cold).

This year has seen an increase in influenza vaccination rates largely driven by the COVID-19 pandemic. From Jan-June there was also a twelve-fold drop in recorded flu cases, compared to 2019. AMA NSW vice-president Andrew Zuschmann said, "What it's telling us is that many of the measures that are working to contain the spread of COVID-19 within the community are also very effective at reducing transmission of influenza."

As of the end of May, more than 7.3 million influenza immunisations had been recorded to the Australian Immunisation Register, compared to 4.5 million in 2019. It is worth noting that this region has the lowest rates of vaccination in the country.

This pandemic and the rise in people seeking influenza vaccinations offers health care workers the opportunity to encourage vaccinations and ensure vaccination status is up to date, whilst perhaps discussing potential future COVID-19 vaccinations. We must remember to acknowledge concerns that patients may have regarding vaccination safety and efficacy in a manner that does not overwhelm or dismiss them.

Supportive material may be useful and the National Centre for Immunisation Research and Surveillance has a helpful website to assist with addressing these concerns and accessing accurate safety data.

– a leader has been Oxford University, and its commercial partner, AstraZeneca, has signed a contract of intent with the Australian government to supply 25 million doses.

Announcing this in late August PM Scott Morrison said the free vaccine would be made "as mandatory as possible", although he walked back the comment a few days later to say that nobody would be "forced to be vaccinated".

One group concerned about mandating was the influential AMA, which said that while it was "very supportive of vaccination generally" it felt governments should not compel Australians to get a COVID-19 vaccine, warning that a fast-tracked approval process could create a risk of harmful side effects.

Another group, concerned not by caution but 'civil rights', was Pauline Hanson's One Nation. On the coat tails of the PM's comments **Sen. Hanson released an impassioned video** saying, "I'm not happy about this. I'm quite angry because you have no right to say that I have to have this vaccination, because I tell you what, I won't be having it... I don't have the flu vaccination, that's my choice, even though I know 1200 Australians died last year, yet you never shut down the country."

Senator Pauline Hanson opposes having flu and Covid-19 vaccination.

The senator, who holds a key vote in parliament and generally supports the government, went on to claim that the coronavirus death toll had been exaggerated, alleging, "When you falsify the deaths of people that say they died of COVID when they actually died of other underlying issues ... to put a vaccine into my body that hasn't been tested is not happening."

Along with state border closures and tight restrictions on Australians wishing to travel overseas, the vaccination issue highlights how a public health concern has moved from a bipartisan consensus to a politically divisive issue with the potential to impact on the health of many people.

UOW medical students – Welcome to the North Coast

In July 2020, a cohort of 19 University of Wollongong senior medical students relocated to the NSW North Coast, from Murwillumbah in the north-west to Kyogle, east to Ballina and south to Grafton, in order to complete their 12-month longitudinal integrated placement in general practice, hospital and community health settings.

Whilst here these students will have clinical experiences in various disciplines, including surgery, medicine, general practice, paediatrics, obstetrics and gynaecology, and emergency medicine. They will spend the next year living, working and learning alongside our local clinicians, as well as enjoying the beautiful country lifestyle in our region.

UOW's graduate medicine students are selected not only for their high academic achievements but for their personal qualities and experiences and proven commitment to rural and regional communities.

During their orientation week, students attended a clinical skills workshop at the University Centre for Rural Health (UCRH) North Coast in Lismore, participating in skills stations such as intravenous cannulation, basic life support and suturing workshops. The students also attended an Aboriginal Health Day facilitated by Emma Walke, Academic Lead Aboriginal Health, and Susan Parker-Pavlovic, Associate Lecturer Aboriginal Health from UCRH, with the presenters encouraging the students to reflect on their own attitudes and behaviours in understanding cultural differences, essential in order to provide the best possible care to patients.

The University of Wollongong's medical program was established with the primary aim of helping to address the critical shortage of medical practitioners outside major cities, and actively recruits students who have rural backgrounds. In addition to the students who have just commenced in the region, 10 final year students continue to train in the region as part of final year placements and a number are also working in Lismore Base Hospital or Tweed Hospital under the NSW Ministry of Health's Assistant in Medicine program.

These medical students are grateful to have the opportunity to learn and experience rural medicine in this region.

One of the best ways to encourage young doctors to make career choices to work in rural communities after they graduate is to introduce them to life in a regional town while they are students.

Joanne Chad UOW Program Coordinator

19 UOW Medical Students from Murwillumbah, Kyogle, Ballina, Lismore, Grafton and Maclean

UOW medical student Jasmine Pickard and UCRH Educator Frances Barraclough

Northern NSW gets a Medical Workforce Plan

Medical student Cassandra Byers

Medical student Thomas Skinner

Billed as "a new roadmap which brings together health partners from the acute and primary health and tertiary education spaces", the Northern NSW Medical Workforce Plan 2020-2026 released on 30 June 2020 charts how primary health, regional training and the hospital system can work together to identify and plan for the health needs of the region.

A specific focus is the medical workforce that will be needed in years to come, according to Professor Ross Bailie, Director, University Centre for Rural Health, who said giving junior doctors a clear pathway for rural and regional training placements is key to securing their interest in working regionally in the longer term.

"Increased training opportunities should enable early career doctors to stay and work in rural areas without the need to return to metropolitan-based teaching hospitals to further their training," Prof Bailie said.

"It is vital that the training opportunities in rural and remote Australia are in the areas where there's going to be a future need, and this plan helps us determine where those needs will be."

Collaborating in the plan are the Northern NSW Regional Training Hub – Lismore (The University of Sydney), the Clarence Valley Training Hub (University of Wollongong), the Northern NSW Local Health District (NNSWLHD) and North Coast Primary Health Network (NCPHN).

NNSWLHD Chief Executive, Wayne Jones said, "Rural training and career opportunities are an essential stepping stone to having a strong health workforce.

"Attracting early career doctors to stay and work in rural areas also relies on having comprehensive training available outside metropolitan centres.

"We're already making inroads, but this strategic planning and analysis highlights how important it is to work together in having a sustainable medical workforce for our communities."

The plan builds on the available medical placements and training in the Richmond and Clarence Valleys to provide a basis for a framework to develop the medical workforce over the next seven years, taking into account population growth to determine future medical workforce needs to 2026.

The Northern NSW Regional Training Hubs (RTHs) in the Richmond and Clarence Valleys are part of a national strategy that aims to strengthen the rural health workforce by providing rural training and career opportunities for junior doctors.

"We've seen very promising ideas at both the state and federal levels, resulting in programs which will allow young medical practitioners to complete various stages of their medical training in rural areas," said University of Wollongong Dean of Graduate Medicine, Paul de Souza.

"Through the development of specific rural health departments in universities, the establishment of rural clinical schools, increased placement opportunities in rural areas, the recent establishment of Assistants in Medicine positions, and pilot programs of rural junior medical officer training and employment, we can now see there are growing opportunities to attract medical students and graduates to rural and remote communities, which has immense benefits for the health of this region."

The Medical Workforce Plan forms the framework for delivering integrated rural training pipelines that benefit regional medical students, as well as other young people in rural areas who might be thinking about studying medicine but are keen to stay close to home.

The Northern NSW Medical Workforce Plan 2020-2026 is viewable on the Northern NSW LHD website.

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