Marie McInerney reported on the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) Conference held in Darwin for the Croakey Conference News Service in May 2024.

We pay our respects to the Traditional Custodians of the country where we live, work and travel upon, and to Elders, past, present and future.
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Landmark conference to focus on community, innovation – and the unique healthcare environment in the Northern Territory

Introduction by Croakey: The importance of community and holistic healthcare was highlighted at the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) conference.

The annual conference for radiographers, sonographers, radiation therapists, nuclear medicine practitioners and the wider medical radiation sciences community took place from 9-12 May on Larrakia Country in the Northern Territory. It is the first time the conference has been held in the Top End.

Marie McInerney, who covered the event for the Croakey Conference News Service, previews the #ASMIRT2024 discussions below.
Marie McInerney writes:

Community is a “vital theme” for Top End residents, particularly for Aboriginal and Torres Strait Islander patients coming to Darwin from remote communities, according to Royal Darwin Hospital radiographer Kim Hayward.

“In the 10-15 minutes we’re spending with the patient to undertake their imaging, we can help build a rapport that will impact their journey in hospital and potentially whether or not they engage with their treatment or come back to the hospital again,” says Hayward, who is a national convenor for a major medical radiation sciences conference on Larrakia Country in Darwin.

“I’m a huge advocate of the role that medical radiation practitioners play in holistic healthcare and the impact we can have on a patient’s journey,” she told Croakey.

While proud of the skills that she and her colleagues have developed, one of the costs of working in Darwin, where Hayward has been for more than 20 years now, is the restricted access to professional development.

She and her colleagues “can’t just pop down the road to another comparable hospital and see how they’re doing things”. Hayward says: Our closest ‘pop down the road’ hospital is Townsville, 2,500 kilometres away.”

So Hayward tries each year to attend the annual conference hosted by at the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT), taking annual leave to do so.

That makes her doubly pleased that the 2024 ASMIRT conference is being held in Darwin from 9-12 May, bringing together more than 700 people from across the medical radiation sciences profession, including radiographers, sonographers, radiation therapists, and nuclear medicine practitioners.

The event is an opportunity for Hayward and her local colleagues to meet with practitioners from across the country and internationally, to exchange information, research and practice skills across clinical, technological, research and workforce issues.

Unique environment

This year’s conference will have a particular focus on Top End issues and expertise, “a Darwin flavour” that also highlights the unique environment that Northern Territory medical radiation practitioners operate in and the expertise and responses they have developed.

“This is the first time ASMIRT has brought the conference to the Top End, so we wanted to do something a little bit different, to highlight why working here is unique for our profession,” Hayward said.

At the heart of that difference is climate, remoteness, a unique health demographic with a large and remote Aboriginal and Torres Strait Islander population, and the role Darwin plays as a hub for Asia Pacific disaster/emergency medicine and for regional outreach.

#ASMIRT2024 convenor Kim Hayward
The three-day conference has been brought together by Hayward, fellow conference convenor NT Health radiographer Bec Kilday and ASMIRT under the theme, Colours of Country: Community, Resilience, and Innovation.

The opening plenary will focus on disaster healthcare and the work of the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin, which leads Australian health responses to incidents of local, national and international significance.

That has included deploying Australian Medical Assistance Team (AUSMAT) capability to a host of emergencies over the past 15 years, including the White Island volcano eruption in New Zealand, a trachoma outbreak in the remote NT community of Maningrida, and to the 2018 Papua New Guinea earthquake.

As well as offering a site visit to the NCCTRC, the conference will hear from paramedic and NCCTRC Director Abigail Trewin and former Royal Darwin Hospital radiographer Tom Randall, a specialist in trauma and emergency imaging, speaking on an AUSMAT radiographer’s experience, ‘From typhoons to measles’.

Hayward says the opening session “will set the tone for the conference, that things here are a little bit different, that the work we do is exciting and that we’re presented with unique challenges on a daily and weekly basis”.

That includes regular presentations of diseases that would be somewhat “extraordinary” to see in other parts of Australia, including tuberculosis (TB) and rheumatic heart disease (RHD), which are comparatively prevalent in the Top End, an ongoing concern for the health of Aboriginal and Torres Strait Islander people and regionally.

The conference will hear about innovations in the detection of RHD and presentations on TB globally and locally.
Focus on community

Two sessions are to be led by presentations from Professor Gail Garvey, a proud Goori woman from New South Wales and former long-term Darwin resident, who is a leading researcher on Aboriginal and Torres Strait Islander people and cancer.

She will present on the 4Cs program: Communication and Collaboration in Cancer Care for Aboriginal and Torres Strait Islander people, and moderate a panel discussion including Alan Walker Cancer Centre Aboriginal Liaison Officer Philip Mayo and a patient.

Garvey was recently involved in hosting the World Indigenous Cancer Conference, which Croakey covered: see here.

The conference focus on community will also apply to the broader region, including issues and capacity-building for close neighbours like Timor Leste and Australia’s role and responsibility as a regional health and economic leader.

Each of the three themes have crossover of course, but the second theme, ‘resilience’, also applies to workforce pressures, particularly in remote areas where there is no medical imaging degree offered at the local university and health agencies are forced to recruit from other parts of Australia.

As a result, teams are “often running well below our FTE”, prompting a full session to look at workforce and workplace resilience, including ‘an introduction to impostor phenomenon’ from United Kingdom radiographer and sonographer Associate Professor Gill Harrison.

Advances in technology

As at last year’s conference, the innovation theme also speaks to the rapid evolution of the profession and its technology, including artificial intelligence (AI) which can seem in contradiction to perspectives on community and resilience, Hayward said.

“At a conference like this it’s really important that we talk about those advances and innovations in our profession and how we can embrace the technology without it being at the expense of the human side.

That’s a key interest for fellow Darwin-based convenors Elly Keating and Kiara Spadavecchia, both radiation therapists, who are also excited at the opportunity to showcase local issues and skills, saying it’s a morale booster to be able to fill the program with so much local expertise.

They are keen to hear about how other regional and remote therapists work, particularly as more smaller radiation therapy centres are being earmarked and established across Australia through the Federal Government’s Radiation Oncology Health Program Grants Scheme.

“I’m hoping to hear about the regional and rural delivery of RT [radiation therapy]: what other centres are doing, the trend to smaller centres, the push to make RT more accessible, to hear how they are managing AI etc,” Keating said.

Hayward said the conference will also seek to make sure that nuclear medicine is not “the forgotten sibling”, including through a site visit to the Cyclotron at Royal Darwin Hospital.

The most powerful of its kind in Australia, the Cyclotron means that, for the first time, radioisotopes are now produced locally in the NT, enabling faster diagnosis and treatment, and meaning Territorians no longer have to travel interstate for PET (positron emission tomography) scans to assess cancers, and neurological and cardiovascular diseases.
It was a significant medical advance for the NT, particularly in the wake of COVID-19, which disrupted the supply of isotopes from southern states, leaving patients potentially unable to access PET scans.

But it is landmark in other ways – the $27 million Cyclotron topped the 2022 NT Architecture Awards, hailed for a “humble and somewhat nondescript building (that) houses a labyrinth of extraordinarily complex uses”.

**Sustainability**

The conference will also focus on climate and health, with a session on healthcare, environment and sustainability that will feature efforts to improve the difficult physical environment of the Royal Darwin Hospital campus, which was, incredibly, modelled on the Royal Canberra Hospital, right down, some have it, to the snow shutters on the windows.

One of the speakers, Royal Darwin Hospital specialist emergency physician Dr Mark de Souza, has recently reported that the NT Health workforce is working under “colliding operational pressures worsened by extreme weather events, regional staff shortages and infrastructure that is poorly adapted to climate change”.

He has led work on the H3 Project (Healthy Patients, Workforce and Environment), which explores nature-based interventions in the NT health sector, providing a “platform for improving cultural safety and hospital health outcomes for First Nations Australians, while promoting Indigenous knowledge and leadership in climate adaptation and mitigation efforts in the healthcare system”.

See Croakey’s earlier reports on the the Greening Royal Darwin Hospital project that had planted 950 local native Australian trees and shrubs, half of which were culturally significant species identified by Larrakia plant experts.

Other key presentations at #ASMIRT2024 include sessions on neurodiversity and gender diversity in medical radiation practice and a workshop session titled ‘Surviving Death’ by Sunshine Coast radiation oncologist and author Dr Colin Dicks, based on his book *Death, Dying and Donuts*.

**Challenging professional landscape**

Croakey’s preview of last year’s ASMIRT conference noted it was taking place amid a challenging professional landscape, with increasing demand, growing waiting times, the need for more complex imaging, calls for a new stream of research, scope of practice issues, and worries about recruitment and retention, with graduate numbers way down.

ASMIRT president Carolyn Heyes said much of that challenge remains, with a continuing chronic workforce shortage of all medical radiation professionals, particularly nuclear medicine and radiation therapy although gaps in diagnostic fields are closing.

The biggest issue now, she said, is for universities with growing numbers of students to be able to access clinical placements in overworked and understaffed clinics.

“It’s a bit of a ‘chicken or egg’ situation: if we are fully staffed, we can take on more students, but we won’t all be fully staffed until these students graduate or we get more people from overseas,” she said.

Ahead of a ‘future of the profession’ closing panel session, the conference will hear from key United Kingdom speaker, Dr Rachel Harris, on the development, provision, and regulation of hospital-based radiography ‘apprenticeships’ in the UK that could help address these issues in Australia.
Importantly, students are “paid from day one”, an added attraction for mature age students, she said.

The conference will also consider other professional issues, including advanced practice and role extension, and ongoing discussions about authority for radiographers to be able to ‘comment’, in the absence of radiologists, on clinically significant image findings.

Heyes is also keen for delegates to attend sessions on AI, to allay fears. “AI will make our jobs easier, it’s not going to take our jobs away,” she said.

Beyond that, she said, it is exciting to have the conference in Darwin, the first in the NT since it was held in Alice Springs in 1997.

“I think it’s going to be a real eye opener for a lot of people.”

Follow the conference news on X/Twitter at #ASMIRT2024 and via this X/Twitter list of presenters and participants.
A rare opportunity to hear from the experts responding to disasters and public health emergencies

Introduction by Croakey: As we face a future of intensifying disasters and public health emergencies, the capacity and work of the Australian Medical Assistance Team (AUSMAT) will become ever more important.

Below, experienced AUSMAT personnel share some insider perspectives on their work, following presentations at the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) conference.

Marie McInerney writes:

For radiographer Tom Randell, deployment to the Philippines in 2013 to assist with the shocking toll of Typhoon Haiyan felt like his many years of working in the Royal Darwin Hospital Trauma Service “got condensed into two weeks”.

“Suddenly you see more injuries than you’ve ever seen,” he told the recent 2024 ASMIRT conference, in a keynote speech titled, ‘From typhoons to measles – an AUSMAT radiographer’s experience’.

Radiographer Tom Randell, during an interview with Marie McInerney at #ASMIRT2024
Randell has served five overseas missions with the Australian Medical Assistance Team (AUSMAT). Known as “the SAS of the medical world”, it’s Australia’s multidisciplinary healthcare team which is deployed in response to national or international disasters and emergencies. It is based within the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin.

Since being set up in 2010, in the wake of the 2002 Bali bombings and the 2004 Boxing Day Tsunami, AUSMAT’s teams have undertaken 36 deployments, including 26 during the COVID-19 pandemic.

Disaster threats

Randell’s colleague, Abigail Trewin, NCCTRC Director of Education and Academic Partnerships, also spoke to the opening plenary of #ASMIRT2024, which brought together medical radiation science practitioners from across the country to Darwin, on Larrakia Country, for three days.

Trewin quoted former Indonesian President Susilo Bambang Yudhoyono as saying the Asia Pacific represented “the supermarket of disaster”.

“If you can imagine it, it can happen in our region and the population and the density and the challenges that presents is extraordinary,” she told delegates ahead of a site visit to the NCCTRC, which highlighted the role of radiography in national and regional disaster and emergency work.

The demand is not subsiding. Asia and the Pacific suffer from more natural disasters than other developing regions and nowhere on the planet is the escalating threat of climate change-induced disasters greater than in the Asia Pacific, according to the UN’s Economic and Social Commission for Asia and the Pacific.

Climate change also heightens the risk of infectious diseases like COVID-19, with the pandemic prompting a huge surge in AUSMAT’s missions nationally and regionally, with deployments “to the trickiest or most wicked COVID problems”.

AUSMAT’s teams were marshalled in the earliest and riskiest days of the pandemic to make multiple flights to China to repatriate Australians from Wuhan, the epicentre of the virus, and managed the deadly and highly political outbreak on the MV Artania cruise ship off the coast of Western Australia in 2020.
AUSMAT also set up and ran the Howard Springs COVID-19 quarantine facility in Darwin. Its teams were deployed to Melbourne’s aged care homes as COVID-19 took a serious early toll in Victoria, and to Fiji, Papua New Guinea and Timor Leste when local services were under pressure.

The pandemic cumulatively served as “the biggest example of why you have an asset like this... so you can do the things that other health systems perhaps aren’t able to do right now,” Trewin said.

Other public health emergency missions have ranged from a 2013 outbreak of trachoma in Maningrida in Arnhem Land to the 2019 major measles outbreak in Samoa, which resulted in 83 deaths.

“There’s the assumption that we’re just here to do disasters with traumas,” Trewin later told Croakey.

“We’re not. When we do a response, it has to be an integrated [one] so we really look at everything from the local population we are serving, to the health facilities we are supporting, right through to waste [generated], and ensuring we report back appropriately to the Ministry of Health that’s impacted so they can make meaningful decisions about what to do next,” she said.

Public health “is incredibly important to us,” she said, foreshadowing a major announcement in the coming months about building public health capacity across the Asia Pacific. “Watch this space,” she said.

See this interview with Trewin at the NCCTRC.

Abigail Trewin presenting at ASMIRT2024
Some history
Outlining the origins of AUSMAT and the NCCTRC, Trewin said Australia sent medical support to the devastating 2004 Boxing Day tsunami, putting together civilian teams that “scrabbled together equipment, supplies, whatever they could find from their local hospitals”.

Many lessons from that experience framed the direction Australia later took, as did the Bali bombings in 2002 when the Royal Darwin Hospital did “extraordinary work”, treating 77 survivors with critical injuries, 55 of them with major burns, she said. It was a “miraculous” response, considering the size of the hospital and the infrastructure available.

But the fact that it took 20-plus hours to retrieve patients, when Bali is less than three hours away by plane, prompted then Prime Minister John Howard to order a national capability “to do this better”, which ultimately evolved into AUSMAT and the establishment of the NCCTRC, she said.

Beginning with just one shipping container worth of resources, AUSMAT now can set up field hospitals with paediatric, adult and surgical wards and, a six-bed intensive care unit, mainly for respiratory care.

AUSMAT teams may also play an advisory role to a host nation or another emergency management team, with much work also invested in upskilling local staff in regional countries, recognising that the impact of disasters continues beyond emergency responses.

NCCTRC is federally funded under an agreement between the Northern Territory and Federal governments. Last night’s Budget allocated $55 million over three years, to “allow the NCCTRC to maintain the staff, equipment and resources needed for 24/7 peak preparedness”.

In an earlier announcement of the funding, Butler noted that the NCCTRC is a specialist trauma medicine hub for northern Australia. It provides an injury prevention program in the Northern Territory, trauma and disaster research, and education for clinicians across Australia, South East Asia and Pacific countries.

About 70 percent of the NCCTRC’s funding invests in AUSMAT capability, Trewin said. “We train large numbers of Australians within the health system to be ready to go. We innovate and develop new equipment to ensure what we do is appropriate and fit for purpose,” she said.

That innovation has seen AUSMAT build its own water filtration systems to standards sufficient to be able to use in surgery if needed and the capability to “make our own oxygen in the field”.

Sign up
Trewin invited allied health professions to sign up to AUSMAT’S database — but with caveats, as she described the organisation’s exacting, military-like recruitment processes, particularly a psychological personality test looking for team spirit.

“It’s not a reflection on whether you’re great at your job,” she said, “it’s a reflection on whether you will play well in this team and whether you are suitable to work in the environment we’re sending you into because we have mental health as a key factor to think about, and resilience is a really important element of these types of responses.”
All applicants, from surgeons down, get tested for their willingness to wash floors, empty the waste, and build field hospitals, and multiple skillsets are highly valued. This weeds out both “princesses” and “one trick ponies”, she said. Logistics personnel are rated as among its most important team members and, despite some of the physical challenges, maturity is preferred.

“Forthy is good, 40-plus is even better,” she said. “We want five years postgraduate experience, preferably, which means we’re all older, maybe a little crankier. But it brings a wealth of experience to the table. It also brings, we find, a calmness — most people have had enough life experience to know when to react and when not to.

“It makes a big difference to the team and the team morale. Teams are not just about the skills you bring. It’s about your personality,” Trewin said.

“You could be the best surgeon but, if you’re a rubbish team player, AUSMAT is not for you.”
Training matters

The military approach also applies to training: “We train as we mean to deploy,” says Trewin.

That can see trainees ‘ambushed’ by Tactical Response Group officers, “because we know from Chechnya and other UN events that people not exposed to the reality of what they may face will have terrible mental health outcomes, so we show our people how bad it could get and then put in the systems to protect them as best we can”.

The point is it allows would-be team members to ask themselves: “Do I want to do this? Am I up for sleeping in the dirt, crappy showers, terrorising events, huge stress levels, ridiculous heat?” And if they say yes? “AUSMAT is for them,” she said.

For Tom Randell, who had specialised in trauma and emergency radiography, it was a resounding yes. “A challenging work environment is great. That’s when you can do your best work, I feel.”

He told the conference about his first deployment to the Philippines, where a fishing village had been washed away and 15,000 people made homeless overnight. Many had “really traumatic injuries” caused by flying debris, compounded by lower nutrition levels that meant reduced bone density.

Another harrowing deployment was the measles outbreak in Samoa, where, in the pouring rain, the AUSMAT team built a neonatal ICU in the carpark of a hospital.

With a total population of just over 200,000 people, the country suffered 5,707 measles cases and 83 measles-related deaths — 87 percent of them reported as children younger than five years. It was, he said, “really tough and draining on your emotions” to see so many very sick children, with measles attacking the immune system and making infected people susceptible to many infections.

Randell’s most recent role was supporting a national tuberculosis (TB) surveillance prevalence study in Timor Leste in 2023, led jointly by the Menzies School of Health Research with the Timor Leste Ministry of Health.

Menzies team presenting at #ASMIRT2024. Credit Patrick Hamilton/ASMIRT
Timorese members of the Menzies team, Jorgelino Guetteres, Deonizio Gusamo, and Goncalo Pinto, alongside Australian colleagues Dr Chris Lowbridge and Dr Joshua Francis, presented the work at the conference, telling delegates that Timor Leste has one of the highest burdens of TB in the world, but that uncertainty around data affects planning capacity.

“Having a good grasp of the epidemiology of TB is really important,” Lowbridge said.

The small team visited 5,000 households in 50 villages, screening more than 15,000 people. It was a huge logistical exercise with some mountainous villages only accessible by foot and having no electricity. “We became very fit!” Pinto commented.

Randell’s role was to support Timorese health staff to use the equipment, including “incredible” solar-powered backpack X-ray machines that contrasted with the units he first used a decade ago at AUSMAT that were so big “they wouldn’t go in most commercial airlines”.

**Watch this interview with Tom Randell**

![Interview](https://example.com/)

**Ambitious goal**

TB, the world’s deadliest infectious disease, remains a “massive problem” globally, with around 10 million new cases every year, and high numbers of death, said Francis, a paediatrician and infectious diseases specialist at Royal Darwin Hospital and Associate Professor at Menzies School of Health Research, who provided a global and local overview of the disease to open the session on ‘TB across the Timor Sea’.

Notably, incidence of TB in Australia is “incredibly low, very different to much of the region around us,” he said. But not for everyone, with Aboriginal and Torres Strait Islander people particularly at risk. Incidence in Australia is around five per 100,000 people per year, while in the Northern Territory the rate is more than 10 per 100,000 with even higher rates in some remote communities, he said.

Francis is concerned that this alarming prevalence is not fully recognised in Australia, saying ongoing transmission in Aboriginal and Torres Strait Islander communities needs “really careful attention” and stronger partnerships between health services and communities to end the TB epidemic in these places.

Unlike COVID, Francis said, TB does not spread rapidly, more as a “slower grumble”, which has continued to transmit, mostly via households, “over generations and generations”. It starts in the lungs, but can spread to the lymph nodes, to bone, or to the central nervous system, and present with a myriad of different symptoms.
That means it can be difficult to detect clinically and diagnosis relies on having accurate tests — chest x-rays and the work of radiographers are critical, he said.

The World Health Organization’s (WHO) latest Results Report, showcasing key public health milestones, said 2023 saw the highest number of with TB to get treatment since monitoring began almost 30 years ago, after the first-ever alloral treatment regimens for multidrug-resistant tuberculosis made available in 2022.

But it’s complex work, Francis said, given that TB is a slow replicating bacteria that requires a long course of treatment, usually at least for six months and up to four different medications.

The global aim to reduce TB incidence by 90 percent by 2030 is “incredibly ambitious”, he said.

“We have tools that can work, but it’s about investing in and using them as we can,” he said.

Francis also presented to the conference on the use of handheld echocardiography devices for the early detection of rheumatic heart disease (RHD), which Aboriginal and Torres Strait Islander people in the Northern Territory are at least 125 times more likely to develop than non-Indigenous Australians.

Here’s a Twitter thread of the #ASMIRT2024 opening plenary.

Read more on TB here.
Watch this interview with Abigail Trewin

Published on Wednesday, May 15, 2024
Medical radiation science students face ‘placement poverty’: urgent call for inclusion in Commonwealth Prac Payment

Introduction by Croakey: Amid national workforce shortages, Australia’s peak medical radiation science organisations have called for the Federal Government to include their students in its newly proposed ‘placement payment’ initiative.

With concerns over ‘placement poverty’, the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) and Australian and New Zealand Society of Nuclear Medicine (ANZSNM) have written a joint letter to Federal Ministers, saying it is critical that medical radiation science students are supported.

Below, Marie McInerney reports on workforce issues discussed at the annual ASMIRT conference.

Marie McInerney writes:

Australia’s peak medical radiation science bodies are urging the Federal Government to include radiation therapy, diagnostic imaging and nuclear medicine students in its proposed new paid placements scheme, warning that some are having to sleep in cars or tents while undergoing placements.
Carolyn Heyes, president of the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT), said that ‘placement poverty’ was a real and distressing issue for medical radiation students and a factor in critical and chronic workforce shortages that were exacerbated by the COVID-19 pandemic.

“Placement poverty is a very big deal for [our students] and we actually have students quit because they can’t afford to do a six month or 12-week placement,” she told Croakey.

The three-day conference brought together more than 600 medical radiation science professionals from across the country and internationally for a program under the themes: Community. Resilience. Innovation.

As well as a big focus on clinical and patient centred care, the conference discussed significant workforce pressures, with chronic shortages in workplaces across Australia and globally.

Heyes said ASMIRT is “very, very disappointed” for its students not to be included in the new Commonwealth Prac Payment – set up to support teaching, nursing, midwife and social work students undertaking mandatory workplace placements required for university and vocational education and training qualifications.

Under the scheme, eligible students will be provided $319.50 per week – which is benchmarked to the single Austudy rate – from 1 July 2025.

Financial burden

ASMIRT and the Australian and New Zealand Society of Nuclear Medicine (ANZSNM) have written this week to Federal Ministers, noting that the combined medical radiation sciences are “key professional areas instrumental in delivering diagnoses and treatment across a range of health conditions, in particular cancer”.

They say the demand for diagnostic imaging (DI) for x-ray, CT and MRI scans, nuclear medicine (NM), including theranostics, and radiation therapy (RT) has expanded exponentially in recent years resulting in a chronic national workforce shortage.

“This has now become critical,” their joint letter says.

Both organisations’ respective national conferences have identified contributing issues around training – in particular, the financial burden of rural, regional and interstate clinical placements.

The organisations say their students are required to undertake more than 52 weeks of clinical placements throughout their four-year undergraduate degree course.

“Unlike medical students, they are not provided with free accommodation, and they often have to relinquish their part-time, paid jobs to undertake these unpaid placements, particularly if the placements are in rural/regional locations or interstate,” they write. “We have examples of students having to sleep in their cars, or in tents.”

While they applaud the scheme for its recognition of the shortage of healthcare professionals, they are “most concerned” that medical radiation science students are not included, despite widespread workforce shortages and the professions being listed as priorities for Australia.

“With the rapidly increasing number of medical radiation services performed, it is critical that we continue to support and supply a viable graduate workforce,” they said, urging the Government to think beyond just doctors and nurses when it comes to investment in the health workforce.
Workforce under pressure

In an interview with Croakey at the conference, Heyes said ASMIRT is also in negotiations with unions to try to equalise professional awards across Australia, to stop an ongoing “exodus” to the better paying states like Queensland.

As Croakey reported last year, workforce shortages in the medical radiation sciences in Australia and globally have put the profession in a “state of stress” which risks further depleting numbers and is pitting jurisdictions against each other.

“We firmly believe Australia-wide we have the same qualifications and we do the same work, with slight variations obviously, depending on the patient population, but we think everyone should get the same remuneration and same conditions,” Heyes said.

“It’s trying to get all those things even so people can choose to work in the state because they love the state or they come from there, they’re not having to leave to go elsewhere to get the better conditions.”

At the conference, a session on the future of medical radiation sciences heard that its workforce makes up 2.2 percent of all health professionals – nearly 80 percent are diagnostic radiographers, 14 percent are radiation therapists, and seven percent are nuclear medicine technologists.

Seventy percent of the professions are female, while Aboriginal and Torres Strait Islander people make up less than one percent, with just 131 practitioners out of a total workforce of just under 20,000.

Heyes told the session that the profession is in some ways a victim of its own success, with university requirements for access now “really high”, above 95 percent.

“I would have had a snowball’s chance in hell of getting into the course now,” she said, noting that career pathways, including that advanced practice is still in its early days in Australia, then become major issues.
Students “are super bright, they want to be in charge in five years…which all of us know doesn’t necessarily happen so they move on to other professions, we are of course a stepping stone to medicine”, she said, citing a 25 percent drop out rate by five years after qualification.

Heyes, who is based at the Royal Children’s Hospital in Melbourne, said demand on medical radiation services is also reflecting financial distress in the community.

“A lot more people are using our ED [Emergency Department] as a GP clinic,” she said.

**Earn while you learn**

Medical radiation sciences in the United Kingdom also have a “massive retention and recruitment problem”, with the National Health Service “on its knees”, said Dr Rachel Harris, Head of Professional Practice and Education at the Society and College of Radiographers in the UK.

“Even the ones we manage to recruit we’re losing because they’re now in a system where they’re in absolute burnout,” she said.

UK students have also struggled to afford placements, with the result that universities are having to move into more simulation, which she said was another controversial issue.

To help address recruitment, the UK has moved towards an apprenticeship model of study in hospital departments — “a nice way to grow a local workforce” — which is being watched carefully by the Australian profession amid plans for a trial program in nuclear medicine.

Harris said the biggest benefit is the capacity to “earn while you learn”, which is particularly attractive to more mature students who might have a young family or other commitments and cannot afford to go without a wage.

“Therefore we believe we’re widening access to people who might otherwise not come into the profession,” she said, though acknowledging there are also many challenges to an apprentice system, not least capacity in hospital departments to support it.

**Apprenticeship benefits and challenges**

![Benefits/opportunities of apprenticeships](image)
Noting that 98 percent of people in hospitals now undergo some form of imaging, Harris said the profession is in part “a victim of its own success”. “No clinician is going to risk not doing imaging now so I can’t see that changing,” she said.

Nonetheless the session heard that Australia’s Medical Radiation Practice Board is developing a statement on low value care, with a survey showing most professionals report having to do low value care at times, with many not feeling empowered to say no.

Watch this interview with Carolyn Heyes on placement poverty, equitable awards, apprenticeship training and highlights from #ASMIRT2024.

The 2024-2025 Federal Budget restored indexation of nuclear medicine items on the Medical Benefits Schedule, a step long urged by the Rural Alliance In Nuclear Scintigraphy (RAINS), which works in partnership with ASMIRT.

RAINS committee member Professor Geoff Currie tweeted that the move would “support practices, particularly in regional and remote areas, to remain viable and will improve patient affordability for nuclear medicine imaging services”.

He said: “Now for [the] workforce crisis!”

Further reading

What about me? Paid placements for some university students, but not others, by Kate Mansfield at Charles Sturt University

What does the new Commonwealth Prac Payment mean for students? Will it do enough to end ‘placement poverty’? by Professor Deanna Grant-Smith and Professor Paula McDonald in The Conversation
You can track Croakey’s coverage of the conference here.

From X/Twitter

Marie McInerney @mariemcinerney · May 8
#ASMIRT2024 cc @WePublicHealth @CroakeyNews @MelissaSweetDr

Prof Geoff Currie AM @DrGeoffCurrie · May 8
3. Placement poverty was caused by Fed & State Govts who drove move from 3 yr degree with paid PDY to 4 yr with unpaid residency. None of savings by state govts was reinvested in student placement. All Govts should be addressing placement poverty across all health professions. x.com/DrGeoffCurrie/

Melissa Sweet @MelissaSweetDr · May 8
The students left out of Labor’s promised placement payments
Cc #ASMIRT2024 @CroakeyNews @WePublicHealth @ASMIrtorg @mariemcinerney

From theguardian.com

Follow #ASMIRT2024 on X/Twitter for more discussions from the conference.

Croakey News @CroakeyNews · May 10
Replying to @CroakeyNews and @ASMIrtorg
Nicole Brown quotes a Larrakia Elder. We talk to Country, our Country talks to us. This is our Country. We are Larrakia. She hopes #ASMIRT2024 will be filled with learning, understanding and unity, urges people to respect and explore Country, incl Old Man Rock at Casuarina Beach

Johnathan Hewis @johnhewls · May 8
Excited to be in Darwin for the first time. Looking forward to a great #asmirt2024

Medical radiation science students face ‘placement poverty’: urgent call for inclusion in Commonwealth Prac Payment

#ASMIRT2024

Croakey
“Conference News Service”
Medical radiation science students face ‘placement poverty’: urgent call for inclusion in Commonwealth Prac Payment

#ASMIRT2024

Croakey News @CroakeyNews · May 9
Hi from Larrakia Country in Darwin where @mariemcinerney is covering #ASMIRT2024, the annual gathering of medical radiation sciences, being held in the Top End for the first time.

Croakey News @CroakeyNews · May 12
Replying to @CroakeyNews
Not quite Aurora australis, but an amazing vista in Darwin, on Larrakia Country, plus massive set up for #ASMIRT2024 conference dinner (see @ultrasoundPG on getting up close and personal with the wildlife pix)

Gill Harrison PFHEA (she/her) @UltrasoundPG · May 8
Getting ready for #ASMIRT2024

Darwin and the conference centre looking great.

@SoRRachelHarris and I are both there for pre conference workshops tomorrow. Hoping we can meet lots of #radiographers and #sonographers to learn and together @SCoRMembers

You can track Croakey’s coverage of the conference here.
Medical radiation science students face 'placement poverty': urgent call for inclusion in Commonwealth Prac Payment

#ASMIRT2024

You can track Croakey’s coverage of the conference here.

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Croakey News @CroakeyNews · May 10
#ASMIRT2024 Sundowner #MindilBeach #LarrakiaCountry

Croakey News @CroakeyNews · May 10
Replying to @CroakeyNews
Great to meet many of the @ASMIRTorg folk, plus #ASMIRT2024 convenors and presenters at workshop sessions y’day. Here’s a few pix

Croakey News @CroakeyNews · May 10
#ASMIRT2024 kicks off today in Darwin on Larrakia Country, with more than 600 delegates from across the medical radiation sciences. The conference themes are: Community. Resilience. Innovation. @marlemcinerney will be live tweeting from this account.
Medical radiation science students face ‘placement poverty’: urgent call for inclusion in Commonwealth Prac Payment

#ASMIRT2024

Published on Wednesday, May 15, 2024
Improving cancer care for Aboriginal and Torres Strait Islander people: experts share knowledge

Introduction by Croakey: Wide-ranging suggestions for improving cancer care and outcomes for Aboriginal and Torres Strait Islander people emerged from a panel discussion at the recent Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) conference.

Marie McInerney writes:

Improving Aboriginal and Torres Strait Islander peoples’ experiences of cancer care and treatment outcomes requires determined efforts across health systems to improve communication and build trust, a medical radiation sciences conference has been told.

Health professionals and systems must also develop their understanding of the cultural determinants of health, and embed cultural safety in their work, the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) conference was told.

#ASMIRT2024 hosted a panel discussion around a hypothetical patient called Henry from a remote Northern Territory community, exploring optimal cancer care pathways for Aboriginal and Torres Strait Islander patients and the factors contributing to poorer cancer outcomes.
Panel members included patient advocate Desmond Mayo, who spoke of his treatment and recovery from throat cancer, and staff from the Royal Darwin Hospital’s Alan Walker Cancer Care Centre — his nephew Philip Mayo, an Aboriginal Liaison Officer, Giam Kar, Practice Manager and Chief Radiation Therapist, and Caroline McCarthy, Cancer Care Coordinator, as well as leading Indigenous cancer researcher Professor Gail Garvey.

Garvey, a Kamilaroi woman, is Professor of Indigenous Health Research in the Faculty of Medicine at the University of Queensland and has worked for many years with the Alan Walker Cancer Care Centre in Darwin.

Opening her #ASMIRT2024 presentation, she introduced her cultural and Country connections, explaining how important they are for Aboriginal and Torres Strait Islander people.

“And that is exactly the case when they come and see you in the hospital system,” she told the audience of radiographers, sonographers, radiation therapists and nuclear medicine practitioners. “How do you embrace and support who they are as Aboriginal and Torres Strait Islander peoples and where they come from?” she asked.

Garvey told #ASMIRT2024 that Aboriginal and Torres Strait Islander people experience cancer inequity “at every point of the cancer continuum from aetiology through to end-of-life care”, caused by a range of factors including politics and policies (see slide below).

These inequities are cumulative and result in substantially higher mortality rates compared to non-Indigenous Australians, she said.

The disparity in cancer outcomes is particularly wide in the NT, said Giam Kar, who is Executive Director of NT Radiation Oncology.
Communication matters

Garvey has been instrumental in promoting First Nations expertise and knowledge in cancer advocacy, research, prevention and treatment through a series of World Cancer Conferences. At the Third World Indigenous Cancer Conference, held recently in Melbourne, she stressed the importance of “fighting for self-determination, for our health rights, for our cultural rights, for the rights to be treated fairly and not be discriminated against”. (See Croakey’s coverage of WICC2024 here.)

Garvey told #ASMIRT2024 that if there was one thing she could change, in the whole system of engaging on health with Aboriginal and Torres Strait Islander people, it would be communication – for the patient, the patient’s family and support, and for clinicians.

There is currently limited data around health literacy and Aboriginal and Torres Strait Islander people and their experience and understanding, particularly about radiation therapy, she said.

However, studies of the general Australian population show about 60 percent of adults lack basic health literacy and about 80 percent of patients referred to radiation oncology say they have little knowledge about what it is and what to expect, which can stop them engaging with treatment.

Garvey has been involved in a small study with 30 Aboriginal and Torres Strait Islander participants at three regional cancer centres (Darwin, Townsville and Cairns), the first to have examined the impact of radiation therapy education sessions on the knowledge gaps, concerns and support needs of Aboriginal and Torres Strait Islander people with cancer.

While the results are still preliminary and nuanced, the sessions resulted in improved knowledge and reduced concerns, she said.

Garvey has also been leading the 4Cs program: Communication and Collaboration in Cancer Care for Aboriginal and Torres Strait Islander People, which has produced e-learning modules focused on improving communication skills of health professionals, and particularly people working in radiation therapy and radiation oncology.

The modules provide advice on creating safe and culturally sensitive environments, including, for example, the value of silence, when it is used to deeply listen, show respect or show consensus. “A lot of people don’t understand the importance of silence in the context of communication with the Aboriginal and Torres Strait Islander patients,” she said.

The modules were trialled with 32 health professionals from cancer centres in Darwin, Cairns and Townsville, with promising preliminary results, she said.

Garvey also pointed to research by colleagues who investigated the successful strategies of 23 health professionals (medical and radiation oncologists, oncology nurses and Aboriginal Health Workers), and identified six key themes that are important to communication in cancer and its treatment with Aboriginal and Torres Strait Islander people.

Congratulating #ASMIRT2024 for having a strong focus on Aboriginal and Torres Strait Islander people’s experiences in cancer, Garvey urged delegates to also undertake the modules (which are free, here) and to check Cancer Australia’s Our Mob and Cancer.

“We know that clinician and patient communication can significantly influence a patient’s healthcare experience,” she said. “[Poor communication] can result in reduced treatment uptake and also completion, which then results in poorer health outcomes.”
Support is crucial

The panel discussed the importance of support for Aboriginal and Torres Strait Islander people with cancer, to keep them culturally strong and help them navigate a complex health system.

For Desmond Mayo, who was diagnosed after seeing a doctor about a cough, support from his family was critical, particularly in translating health information into lay terms.

“I’m 79 now,” he said. “Growing up in the old days we didn’t know about cancer, the only thing we knew about what leprosy so it’s very important to have someone with you who’s got a bit of knowledge on cancer.”

He says he was lucky, because he lives in Darwin so could remain at home and with family through chemotherapy, and because presenting early with a cough to a responsive and informed doctor ensured he got an early diagnosis.

“I got it in the early stages, treatment was done over eight weeks, finishing 15 months ago, and I’ve come out fine,” he told Croakey.

For patients from outside Darwin, Kar said the Royal Darwin Hospital seeks to engage an Aboriginal Health Worker (AHW) as a support person as early as possible, even when cancer is still just a suspicion. Sometimes patients are too scared to ask what they don’t know, or don’t know what questions to ask, he said.
But he said the AHWs don’t just provide cultural and clinical support to patients. They are also critical to the hospital providing safe, informed care, particularly given the NT has many transient and junior doctors who “may not have culturally safe practices, or don’t understand Aboriginal culture yet”.

The best way for services to be culturally safe, Philip Mayo said, is through roles like his own, especially given that 70 percent of patients seen at the Royal Darwin Hospital are Indigenous.

But Aboriginal and Torres Strait Islander health workers are thin on the ground in cancer care, with AHPRA figures showing they make up less than one percent of the medical radiation sciences profession.

Garvey said she understands there are no Aboriginal and Torres Strait Islander radiation or medical oncologists, and just a few working in radiation therapy. While cancer centres in Darwin, Cairns and Townsville have Aboriginal Liaison Officers or AHWs, most other cancer services don’t, she said.

**Barriers to care-seeking**

The panel discussed a range of reasons why Aboriginal and Torres Strait Islander people from remote communities might present late to a doctor or clinic with cancer-related symptoms or not engage with treatment, including lack of access to a GP or specialist and lack of cultural safety.

Philip Mayo said a diagnosis or treatment of cancer often takes a back seat for his patients, particularly those from remote communities, because there are so many other issues they are dealing with — including, for most, wanting to get back home as soon as possible.

“Cancer is not their priority,” he said. “As rough as it sounds, sometimes cancer is just another thing (for them) to put in the shopping cart.

“You’re looking at a cohort of people [who are] very family centred, everything revolves around family and culture,” he said.

“They’re worried about where their money is coming from, family commitments they have, [so we are] working around those issues to get engagement and get them to understand cancer along the way,” he later told Croakey.

Mayo urged greater investment in interpreters so Aboriginal and Torres Strait Islander people can discuss their needs in Language, and more flexibility in the remote patient travel allowance to keep them connected to community as much as possible.

“We’ve had a family member who was supposed to be here for months and it’s turned out to be for a year-and-a-half now,” he said.

Garvey said there can also be a real lack of understanding about what screening and x-rays involve, with many Aboriginal and Torres Strait Islander people not participating in screening because they worry it’s an ‘identifier’ for cancer, rather than early detection or prevention, particularly when there are no symptoms.

Other barriers to seeking care include fear and shame, where in some communities cancer can be seen as involving ‘payback’ or not being strong enough in culture.

Others might disengage after they’ve begun chemotherapy or other treatment, Desmond Mayo said: “Some will say ‘bugger this, it’s made me sicker than I was before’. They don’t know it’s part of the healing process.”
Treatment

Kar told the session that the Alan Walker Cancer Care Centre has a very quick turnaround from diagnosis to treatment time, not only because of strong processes but because later presentation can mean the patient needs treatment “as soon as possible”.

Cancer Care Coordinator Caroline McCarthy talked about the processes involved, and how having been based at the hospital for 14 years meant she had good relationships with staff across disciplines, so that “when people see me come in, they know that it needs to be done quickly,” she said. “At the end of the day I’m a strong advocate for my patient.”

Royal Darwin Hospital makes a big effort to enable Aboriginal and Torres Strait Islander patients to go home to remote communities between diagnosis and the beginning of treatment, understanding how important it is for them to not be suddenly whisked away indefinitely.

Concern about keeping people away from Country can guide treatment plans at Alan Walker, Kar said. The hospital might shorten the course of treatment or opt for “consolidation instead of radical treatment”, understanding that the best outcome for the patient has to involve cultural as well as clinical considerations.

However, the hospital also seeks to keep remote patients in Darwin for at least two weeks after treatment finishes, because many remote communities cannot provide enough post-treatment support.

If people are discharged too early, they often end up returning to the hospital via the emergency department, McCarthy said.
Survivorship

Garvey said she was recently at a cancer forum in Queensland that highlighted the importance of continuity of care. Indigenous patients reported that they felt they had no support once active treatment stopped, and community controlled primary healthcare services said they were not being updated on what was happening for the patient.

Providing better ‘survivorship support’ is the focus of the Australian Cancer Plan and other strategies going forward, she said.

However, many knowledge gaps remain.

“We don’t really know for Aboriginal and Torres Strait Islander people, what they need after their active treatment and engagement in cancer care ends?” Garvey said.

“What survivorship plans and support do they need going forward? There’s a big gap in knowledge.”

Kar and McCarthy said the Royal Darwin Hospital works at providing a strong ‘handover’ to community health services, through telehealth conversations and multidisciplinary support for GPs with complex patients, along with informal supports.

It has also set up the promising Borroloola Cancer Project, 1,000 kilometres from Darwin, which has employed a trusted community member to act as a cancer navigator.

CCNT – MRM Borroloola Cancer Project

How: Employment of a local, trusted community member.
- Underwent cancer education in Darwin – treatment modalities, met personnel including CCCs and ALOs, tour of local hostels

Tasks: Borroloola Clinic morning meeting to update staff on any issues
- Assists patients who need support in the clinic
- Assists the GPs and nursing staff needing support
- Liaise with Acute Care and Allied Health Providers
- Prevention and Early Detection Education of Community
- Position is supported by RN in Darwin who also helps and advocates for patients during their time in Darwin

Trust is key

The panel heard that negative stories about healthcare spread around remote communities “like wildfire”, born of a lack of trust in health services after harmful past experiences, which is why cultural safety and an understanding of the cultural determinants of health are critical, Kar said.

“The message is, you have to build trust,” Kar said.

“We get a lot of things done when you can get people to trust you, trust the system, trust the organisation, trust the staff,” he said.

“If you don’t have trust, none of this will be achievable.”
More take home messages for improving care

**Take Home Message: Enablers for Henry**

1. Improved cancer awareness - clients and health professionals
2. Exceptional communication link between community clinic and the hospital
3. HCH Care coordinator organised his health and supportive support needs
4. Flexible Patient Assist Travel system
5. Hospital ability to triage and prioritise appointments
6. The Cancer AHP and Cancer Care Coordinator multidisciplinary approach
7. Excellent cultural and supportive care need throughout
8. Continuous management of comorbidities throughout the pathway
9. Comprehensive warm handover from hospital to and from community clinic
10. Comprehensive surveillance and survival plan with support
11. Ability to monitor and track Henry’s progress throughout

Watch this interview with Desmond Mayo and Philip Mayo

Published on Thursday, May 23, 2024
On greening healthcare, the Top End is showing the way

Introduction by Croakey: Amid criticisms over the Federal Government’s missed opportunity to address the climate health emergency in the 2024-2025 Federal budget, specialist emergency physician Dr Mark de Souza has urged health professionals to speak out on issues that affect health.

Marie McInerney reports:

A leading Darwin physician has called on health professionals to do their due diligence on policies that they know will impact badly on health, including the Federal Government’s renewed commitment to gas extraction, in the face of the urgent need to address the climate crisis.

Royal Darwin Hospital specialist emergency physician Dr Mark de Souza, the NT representative of the Doctors for the Environment Sustainable Healthcare SIG (special interest group), has also criticised “undemocratic” moves by some health authorities to stop doctors, nurses and other health professionals from speaking out on important issues that affect health.
There had been clear efforts to do so on last year’s Voice referendum and with “other politically charged issues”, including the health impacts of fracking and of gas processing from the proposed **Middle Arm precinct** on Darwin Harbour, he said.

De Souza spoke at the #ASMIRT2024 conference in Darwin, on Larrakia Country, about the Royal Darwin Hospital Greening Project – a grassroots, volunteer led project, dubbed ‘guerrilla gardening’ – which saw him nominated as Northern Territory **Local Hero** in this year’s Australian of the Year Awards.

He opened his presentation with a graphic slide of northern Australia coloured in sizzling red, taken from a **Climate Council website** mapping the impact on local jurisdictions across Australia of a dangerously warming world.

“He are at the forefront of climate change in the Northern Territory,” he said, detailing predictions that the number of “extremely hot” days will, under worst case scenarios, more than treble by 2050 to 179 days per year, versus 47 on average now.

As importantly, overnight lows will be much higher than 24 degrees, which means people and buildings will not be able to shed heat, he said.

The health system will struggle to deal with that and climate health modelling shows it will be socio-economically disadvantaged people who suffer most, he said.

“If you have energy insecurity, or you’re in public housing without air-conditioning or shade from eaves, you are not going to cool down your premises.”

De Souza, who chairs the Sustainable Healthcare Committee (Top End Region), which advises NT Health on opportunities for sustainability in healthcare, said the disruption of climate change is already apparent in healthcare in the NT.
Grim reality

Research has shown that healthcare professionals are contemplating leaving already underserved rural and regional areas because it is too hot, while increasing incidents of flooding and cyclones are displacing Aboriginal and Torres Strait Islander communities, adding to the already heavy demand on Darwin’s hospitals and to the high rate of Indigenous homelessness already in the city.

“That is the grim reality of Northern Australia and, while adaptation is really important, we should not give up on mitigation of our emissions,” he said.

De Souza told the audience of medical imaging and radiotherapy professionals that he hoped they would leave the conference “looking at the world in different ways” and thinking about what action they could take on the big issues affecting health — climate change, the biodiversity crisis, and Indigenous rights — because change would not come without a groundswell of demand from the community.

“That’s why I want you to consider your own role,” he said, later telling Croakey that health professionals “need to be doing our due diligence: engaging respectfully in debate that we are well equipped for”.

The Greening Project at Royal Darwin Hospital was, he said, “a story of taking action, and I hope when you leave this conference…[it] will make you reconsider what your role is as a healthcare provider, as a radiographer or radiologist – what will be your action in the world going forward?”

De Souza’s comments came amid national criticism of the Federal Government’s Future Gas Strategy, which committed Australia to “new sources of gas supply”, despite evidence that fossil fuels are the primary cause of global warming, and in the lead up to the Federal Budget where climate health was missing in action, with, as one critic said, “not one cent…earmarked for the climate health emergency”.

He told Croakey at the conference that decisions taken to embrace new gas projects are “flouting” climate science.

“As a citizen, as a public health expert, and a public health provider, I’m really concerned that the health service may really suffer from some of the decisions that are being taken today because it’s going to put more work on healthcare services to deliver care and it’s going to create more burden of disease by exacerbating climate change,” he said.
De Souza was speaking in an #ASMIRT2024 session on Healthcare, Environment and Sustainability, which focused on climate health, waste, and the need for climate-adapted restorative spaces in healthcare settings, for the wellbeing of patients and staff.

Also presenting to the session were Renae McBrien, a radiologist who is steering sustainability efforts at Brisbane’s Royal Children’s Hospital, which last year eliminated more than a million pieces of plastic from its operations, and specialist anaesthetist Dr Brian Spain, co-director of surgery and critical care at Royal Darwin Hospital, who talked about the impact of health infrastructure on staff and on healing.

More on each of those presentations below, and you can watch this video interview with Spain and De Souza.

**Inappropriate design**

“You’d wonder why you would build a building like that in the tropics,” Dr Brian Spain told the session.

He was showing a slide of the Royal Darwin Hospital – “a big concrete tower that was completely counter to the way any First Nation people would want to be accommodated” – that, incredibly, was modelled on hospitals in Canberra and Calgary in Canada, reportedly right down to eaves for when it's snowing.

However, since the 1970s when it was built, health systems have increasingly identified the connection between the work environment and staff wellbeing, as well as the impact on patients and their capacity to heal, he said.

As a result, the new Palmerston Regional Hospital, 20 kilometres from Darwin, has been designed in consultation with Aboriginal people from across the NT, a low rise building amid tropical savannah, with a big sense of space, plus outdoor gardens and areas for smoking ceremonies – much more attractive for all patients, “but particularly our First Nations patients”, Spain said.

Palmerston Hospital has air-conditioning but some lounge rooms are left open to the elements, with wire mesh around them to keep the insects out, for patients who want to be exposed to the local environment, to the heat and humidity. Some people hate how cold it is in the Royal Darwin Hospital, he said.

“We know there’s better engagement in healthcare if people can come to an environment where they feel cared for and welcomed and where they enjoy coming to receive the treatment. They are more likely to engage in and complete the healthcare journey,” he said.
Providing culturally safe health environments in Darwin is critical, de Souza said, particularly given that Aboriginal and Torres Strait Islander people make up 30 percent of the NT population and, “due to the social determinants of health”, 70 percent of Royal Darwin Hospital’s inpatients, increasing to 90 percent for renal patients.

Many leave hospital before treatment is complete for a range of reasons, some of which were explored at another session on Indigenous health at the conference.

“That’s really concerning for us when we’re here to deliver equitable care to all people”, he said.

**Transformation**

De Souza described how the Greening Project is transforming the grounds of the Royal Darwin Hospital, as has been detailed in previous Croakey stories here and here.

The ‘before’ pictures were truly grim, from a precinct which the project reported was prone to the urban heat island effect due to a lack of tree canopies and so much paving that surface temperatures could exceed 51 degrees Celsius.

“You certainly wouldn’t take a restorative break outside this doorway,” he said. One hospital visitor had described walking from the carpark to the hospital as being “like an SAS training exercise”.

Led by an army of volunteers and working closely with Larrakia Elder Aunty Bilawara Lee and other knowledge holders, in two-and-a-half years the project has created 16 “biodiversity corridors”, planted more than 1,200 native trees, including 157 different species, and attracted “stacks of bird life”, de Souza said.

Thermal imaging data taken periodically over the project has shown a reduction in land surface temperature of up to 32 degrees Celsius compared to the surrounding paved surfaces.
On greening healthcare, the Top End is showing the way #ASMIRT2024

The project was launched in response to COVID-19-related exhaustion and low morale of frontline healthcare workers, staffing shortages, hospital overcrowding, and workplace aggression, as de Souza and Lee wrote in the *International Journal of Environmental Research and Public Health*.

It was a period of time marked by a rise in patient complaints, particularly about long wait times and a lack of privacy imposed by ‘double bunking’ in cubicles, and critical incidents, which included assaults of staff.

The article warned that rising heat conditions will place an additional burden on the NT’s health services, which are already struggling to manage operational demands.

Describing the approach as “psychological first aid”, de Souza said providing patients and staff with access to biophilic healthcare settings – connecting people and the natural world within built environments – reduces the need for pain medications, can shorten surgical recovery time, increases staff retention and makes people happier.

The Greening Project is part of the bigger H3 Project (Healthy Patients, Workforce and Environment), which explores nature-based interventions via biophilic design in the NT health sector. The aim is to strengthen the resilience and responsiveness of health infrastructure and workforce in a climate-altered future.

Last year the H3 team spearheaded a campaign that saw NT Health last year appoint its first ever Director of Sustainability Action.
De Souza said Indigenous cultural safety, climate adaptation, biodiversity preservation, and promotion of wellbeing are the four pillars by which the project engages with public infrastructure.

Aboriginal and Torres Strait Islander patients have known about biophilia all along, he said, telling the session that, as an Elder and healer, Aunty Bilawara Lee has said she will support any project that allows Larrakia people to carry out their ancient roles of caring for visitors to their Country who are ill and to access traditional medicines and bush tucker.

War against waste

Renae McBrien can rattle off damning statistics related to waste in the health sector at high speed, including that healthcare is responsible for seven percent of the carbon footprint in Australia, with 50 percent of that footprint coming out of hospitals and 50 percent of hospitals’ footprint coming out of operating theatres.

But the one that bothers her most is that “30 percent of every piece of plastic on this planet is generated because of healthcare”.

Plastic is not the devil, she said; the problem is with single use, especially when 67 percent of plastic that comes out of hospitals is in fact recyclable or compostable.

McBrien is the Sustainability Consultant for Children’s Health Queensland, whose work on implementing the Queensland Children’s Hospital’s environmental sustainability plan has featured on the ABC’s War on Waste series.

That work has generated its own impressive big statistics – annually moving over 500,000 kilograms of waste out of landfill and into resource recovery, and removing more than one million pieces of unnecessary single use plastic, a 44 percent diversion rate, not too far off the 67 percent target.

She has launched multiple initiatives across the hospital and community to get there, including an effective ‘bin strategy’, removing bins that are not required, putting them in different locations “so you have to think about the bin”, and seeking to educate staff around issues like how much pharmaceutical waste gets into waterways.

As a result, hospital regulated waste has dropped from 22 tonnes per month to 10 tonnes, saving $64,000 a year.
Circular economy

Other initiatives include:

- Reducing food waste by diverting nearly 22,000 kilograms (85 percent) of all food waste on site, auditing meals to determine what children are not eating, and delivering around 560 kilograms of food to OzHarvest: “anything that is non perishable and has been to a non-infectious patient would never go in the bin”.

- Hosting a monthly ‘medical market’ where different units of the hospital can swap excess items that might be nearing their expiry dates. This is about redistribution and stock accountability, she said, saying expired consumables are an “unknown black hole in health”.

- Offering the many cardboard boxes that come into the hospital to hospital staff who are moving house. “It’s a game changer,” she said. “I move about five staff members a week. That’s something you can do tomorrow,” she told delegates.

- Building ‘circular economy’ partnerships outside the hospital, including with Substation 33, which dismantles and reuses electrical waste, and builds new job skills.

- Donating superseded but fully functioning equipment, ranging from crutches to a heart lung fusion machine, to Timor Leste, Papua New Guinea and Fiji.

Together these initiatives have delivered $1.2 million in cost savings and generated $307,000 income in a year — reducing environmental impact while improving the financial bottom line.

It’s a strategy that she says has won the support of her Chief Financial Officer. “This is not about begging [hospital administration] for the dollars. This is about showing them the dollars,” she said.

It’s also translatable across Australian health services, she said, urging delegates to go back to work with at least one thing they were determined to “make change about”.

Health professionals have a shared huge responsibility to look after the planet. Not doing so will only cause more emergencies and admissions, she said.

“If your hospital does not have an environmental sustainability plan, or a sustainability lead, start the campaign, because this is where it starts,” she said, warning that governance is critical.
“You need to have dedicated roles like mine inside a hospital that drives this, [ensuring] that it’s not volunteer based. We need people who are actually funded to ensure that this is part of your clinical practice.”

Photo supplied by Dr Mark de Souza

From X/Twitter
See this [thread](https://twitter.com) for Marie McInerney’s coverage of the healthcare and sustainability session.

![Twitter post](https://twitter.com)

Published on Thursday, May 23, 2024
Talking about death won’t kill you, and other life lessons

Health professionals attending the Australian Society of Medical Imaging and Radiation conference shared some deeply personal stories, about death and dying, experiences as a cancer patient, and how their work can be heart-breaking.

Marie McInerney writes:

Behind many of the presentations at #ASMIRT2024 were personal stories of inspiration, suffering and learning that have guided medical imaging and radiotherapy professionals in their lives and work.

Here are three.

Story one: Talking about death won’t kill you

We don’t have a choice about whether or not we will die, but if we are lucky and informed we can choose to not “crash and burn” in death but have a “safe, soft and gentle landing”, surrounded by those we love who are also well prepared for the inevitability.

That was the message on death from former radiation oncologist Dr Colin Dicks to medical imaging and radiotherapy professionals at the Australian Society of Medical Imaging and Radiation conference (#ASMIRT2024) in Darwin, on Larrakia Country.
It’s also what inspired him, after decades of treating cancer patients, to write ‘Death, Dying and Donuts’, a “user manual”, and to found Dying to Understand, a not for profit organisation that promotes death literacy, with specific advice for health professionals.

Sunshine Coast-based Dicks, who now works in skin cancer care and runs radiation therapy workshops at Queensland University of Technology, said one of the difficulties in clinical oncology practice is knowing when and how to talk about death with patients and their loved ones.

“I’ve learnt that if we bring this conversation up at the wrong time, it’s disastrous for the doctor-patient relationship…it causes conflict, people don’t forgive us,” he said.

He recalled one patient, a man in his 20s, who was in denial that he was close to death. Dicks told him it was time to face reality, and “he was furious with me”.

But if we don’t face death, it can add pain, distress, and financial cost, and be unbearable for loved ones, he said.

Ahead of his presentation, Dicks told Croakey that he “fell into radiation oncology” as a profession. He had not been enjoying general medical training, but then was assigned to a radiation unit and “immediately fell in love with the work”.

Part of it, he said, is the power and magic of radiation therapy, of the life it can give back to people with cancer, but it was also about being with people on a profound journey where some will be cured and others will die. “You’re not just treating the disease, you get the whole person.”

But in the process, he was struck how ill-equipped many people are for the process of dying, raising a dilemma for health professionals: “Do we intervene? Should we intervene? Should we say something?”

And it’s not just the patients for whom the conversations are difficult, but also for health professionals.
It’s a topic he canvases with QUT students, warning that they will be working in an environment where people are regularly facing death and that being death literate will likely make them better in their care-giving.

“We’re not just treating a brain cancer, we’re treating an emotional cyclone coming through the department, with family, with loss, with changing circumstances.”

Dicks shared some other key lessons with the conference and with Croakey:

1. **We need education to equip us for death**

   For his book, Dicks interviewed two focus groups of people who had been through bereavement due to cancer, asking “what did you know and what did you learn when it came to dying?”. He expected to gather some “hot tips” for how better to inform others but was surprised that most people had been “totally ignorant”.

   They had not known what to expect, they did not understand the process of dying, including what happens to the body in the last stages of life, such as “the death rattle”. This meant that one family arrived back at the bedside of their loved one only minutes before they died, he said.

   That lack of knowledge also extended to understanding medical procedures, with some believing that when doctors would use a syringe driver to deliver a steady flow of painkillers, “they were speeding up death… using it to end life”. They didn’t realise it was used “when death is already at the door,” he said.

   That’s why he wrote the book. As well as being a user manual, it gives people time and space to have those conversations, which do take time. “You can’t rush it. So when we are time poor as doctors, the conversation can go wrong really quickly,” he said.

   “The nice thing about a book is it’s not threatening. You can give it to someone and they can, in their own space, in their own time, page through it.”

2. **There are many costs to not being equipped for death**

   Dicks said the costs of denial or ignorance in dying include emotional toll, but also procedural costs where, instead of facing death, patients and/or their families keep pursuing ways to stay alive.

   He talked of patients undergoing dramatic yet futile interventions, including amputations, risky brain surgery, and travelling overseas for alternative therapies. “We don’t want to talk about death, we just want to keep preserving life,” he said.

   There was responsibility here for doctors to say no.

   “Part of the problem as doctors is we want to save lives and, if we’re not doing that, we think we’re failing in our duty. But…there’s a time when we have to…say we’re not going to save this life, we’re going to respect this life’,” Dicks said.
“To me, the superheroes in medicine are the palliative care teams, because they recognise we are no longer trying to cure...we’re about helping.”

3. **There is always more we can do**

Dicks said it distresses him when doctors say “there’s nothing more we can do”.

“What a terrible place of hopelessness [to say that],” he said.

“We can always do something: we can care, we can listen, we can stand next to someone, we can hold their hand, we can be human.”

4. **Dying is a verb**

Dicks outlines in his book that death is a noun, but dying is a verb, an active process, “very much an action word, a whole lot of things have to happen when you’re busy dying,” he said.

5. **Death education is a positive experience**

Dicks said there is a sense of relief and of control when people realise they don’t have to “crash the plane” when it comes to death, and that they can “land it safely”.

6. **Death is normal**

As Dicks said, “the probability of dying is one. Everyone gets to have a go.”

But what makes it so abnormal, he said, is that it’s generally spoken of as “terrible, nasty, awful”.

“No wonder we are completely dismayed when we think about death,” he says, giving a graphic analogy, that if we were eating an ice-cream and someone said it tasted like urine, “it wouldn’t matter how hard we tried, it wouldn’t taste nice after that”.

At the same time, he said, we have sanitised death.

Instead of being a normal part of our life, as it was 100 years ago, our loved ones’ bodies “get covered up, whisked to the morgue, nobody talks about it and when we talk about it…it’s done in negative terms”.

7. **Make your seconds count**

Dicks said it's important to be able to write our own final chapter, but also to not become obsessed with it.

“People spend enormous time of their life worrying about their last day when they still have all the other days to live, which brings me to the most important question: the 86,400 question.

“Every day is made up of 86,400 seconds — what do we want to do with that day today... What are you doing with your gift of life? Are you enjoying life, are you making it count, are you breathing it in, are you savouring the enjoyment of being alive?”
8. Talking about death won’t kill you

Finally, Dicks urged delegates to be an advocate for death education, to bring up the topic of death at dinner with family and friends. He warns there’ll be a stunned silence for a second or two, but then everyone will get involved.

Story two: Talking from the other side of the machine

Leading United Kingdom radiographer Dr Rachel Harris is a veteran of radiography “from both sides now”, with important messages for her colleagues in how they support their patients.

One key message is take the time to know them because it may save time and distress in the long-term.

Harris, who is Head of Professional Practice and Education at the Society and College of Radiographers in the UK, delivered a very personal presentation at #ASMIRT2024, titled, The other side of the machine: experiencing imaging as a cancer patient.

She told delegates that in 1990 she was diagnosed with a pituitary adenoma, a benign (noncancerous) growth, and experienced a few other health issues over the ensuing decades.

Then in 2016, she was diagnosed with invasive stage 2 breast cancer, and her journey into cancer treatment began, undergoing mammograms, an ultrasound guided biopsy, CT scans, chest x-rays, PET CT scans and radiotherapy.

Following successful treatment, she now only needs an MRI scan every three years. But there have been multiple “scares” along the way, requiring a sternum CT scan, MRI to her spine, and DEXA bone density tests.

“Once you become a cancer patient, you seem to be forever a cancer patient,” she said, laughing as she described herself as being “like an audit of imaging facilities” and confessing to suffering from “scan-anxiety”.

Some of those diagnosis and treatment experiences were good, “or as good as they can be under the circumstances”, she said, such as a one-stop clinic where she could see her doctor, have a mammography and biopsy in an hour.

Some were not good, Harris said.

“Health is a state of not just physical but psychological wellbeing. It is very easy when you’re working in practice to forget psychological and social wellbeing,” she said.
“What’s really important is to remember the individual,” she said. What was important for her was partnership and control – “I don’t want paternalistic care, I want true informed consent,” she said.

As a result, she appreciated having a technician indicate ahead of a formal report that it looked like cancer, though she admitted that might have been because she was a radiographer and it fitted with her skills and understanding.

Dignity was also crucial, but there were times when she was left in a state of undress that caused her distress. “On the third day [it happened], I cried. It made me realise how impactful [modesty] was for me”, she said.

Taking care to cover someone up is “just a little thing, just takes a second.”

So too does values-based healthcare, she said, where health professionals take time to introduce themselves and connect to the patient.

Some of her colleagues say they can’t do that “because it takes too long”, but evidence shows that taking time to listen to a patient and look for informed consent can save time and money over the longer-term.

Harris later told Croakey that she never thought she’d be a cancer patient herself, despite the odds. “When it happens, it’s quite a leveller”.

She knows well how, in a busy clinic, you can be asked what’s coming up next, and respond “it’s another breast” or “another prostate”.

“A breast doesn’t come in on its own,” she notes, emphasising the need to remember the whole person.

Asked if it had changed her practice, Harris said she doesn’t work clinically anymore, but that she had always had a passion for patient centred care and had completed her Master’s degree on the patient experience, interviewing people with head and neck cancers.

 Shockingly, Harris said she has suffered awful criticism at time from fellow health professionals for sharing her story, accusing her of “weaponising” her cancer.

“You don’t share your story lightly and, every time you do it, it takes a little bit of you,” she said. “I do it because it’s important to share.”

Watch this interview with Dr Rachel Harris; and this X/Twitter thread from the session.
Story three: “It really broke my heart”

Ruth Pape found her mission in life after the devastating experience of watching women in her home country of Papua New Guinea go back to their villages to die because lack of access to mammography screening meant their breast cancer was diagnosed far too late.

“It really broke my heart,” Pape told Croakey at #ASMIRT2024. An Australian-based Papua New Guinean radiographer and PhD researcher, she presented at the conference on her research into mammography positioning, which is investigating the influence of body shape, particularly of the thorax or chest, on image quality and therefore effective screening.

Having worked as a full-time diagnostic radiographer and taught medical imaging science courses in Papua New Guinea, she is now undertaking her PhD at the Charles Sturt University School of Dentistry and Medical Sciences in Wagga Wagga.

Pape has previously reported that allied health professions in Papua New Guinea are very much in their infancy in terms of having a workforce of university-qualified practitioners, with a critical shortage in the radiography workforce, where there is just one qualified professional per 27,000 people.

What worries her particularly is that the issue is so acute in rural areas, which is home to 87.5 percent of the Papua New Guinea population. Many areas have no radiographer workforce for a range of reasons, including poor transport, challenging geography and logistics, declining healthcare infrastructure and a lack of medical imaging equipment.

Pape said the School of Medicine and Health Sciences at the University of Papua New Guinea where she completed her Bachelor of Medical Imaging Science is working to develop an assistant radiography program to train practitioners on the ground in rural areas, so they are more likely to equipped and ready to “serve the community where they live”.

She would be keen to see Australia and the Australian medical radiation science profession support the development of the profession, and the equipment needed, in Papua New Guinea.

Watch [this video](#) interview with Ruth Pape.
On thriving, personally and professionally. Some wide-ranging advice from experts at ASMIRT2024

In her final report from the Australian Society of Medical Imaging and Radiation conference, Marie McInerney brings advice on dealing with imposter syndrome, building a cohesive professional identity, making workplaces more supportive for part-time workers and mothers, and supporting students who live with neurodiverse conditions during clinical placements.

Don’t miss the video interviews with key presenters, conference photos and links to many useful resources.
Marie McInerney writes:

What does it take to thrive, both personally and professionally?

This question was addressed, in different ways, by many presenters at ASMIRT2024, and our final report from the conference presents a smorgasbord of takeaways from across the four-day program.

1. Forging a visible global medical imaging and radiation therapy identity

A worldwide shortage of qualified workers, variations in entry level and qualifications, and lack of access to medical radiation healthcare for many poorer nations are the top three pressing issues for the medical imaging and radiation therapy professions globally.

That’s the verdict from Steve Lacey, a Melbourne-based radiographer, who is director of education for the International Society of Radiographers and Radiological Technologists (ISRRT), which represents 90 member societies worldwide and 500,000 medical radiation science professionals.

Lacey presented to #ASMIRT2024 on the role of the ISRRT and how it has been working to establish a stronger identity and profile for the professions it represents.

A 2015 survey exploring standard classification of occupations found there were 21 different names applied to the professions across the world, including the Swedish term ‘x-ray nurse’.

“How are we supposed to establish ourselves as a global profession if we … have all of these names?” he asked.

There’s also significant variation in entry level education, context of the radiography role, and scope of practice, he said. For example, in some countries, like Australia, a four-year undergraduate degree allows a student to do medical imaging, radiotherapy or nuclear medicine, while students in other countries can do all three together, while others graduate with a two year diploma.

Such variation in terms and qualifications makes for an “invisible global professional identity,” Lacey told #ASMIRT. “It’s really hard to say to the world, ‘we are one standard profession’”, he said, describing efforts by the ISRRT to standardise education frameworks and adopt official terminology for the professions as radiographers or radiologic technologists.

Lacey, who worked at the Royal Children’s Hospital (RCH) in Melbourne for 15 years before moving now to be director of education at ASMIRT, also presented at the conference on ‘Confessions of a Podcaster’.

As an RCH allied health outreach educator, he has been involved in the broadcast of two podcasts: Teach Think Treat, a clinical education tool for students, and Conversation with the Experts on paediatric healthcare.

His key tip for podcasters? Don’t read from a script.
Watch this interview with Steve Lacey

2. Part-time is not code for giving up

‘Mumography – super skill or career killer?’ That was the sharp question posed on behalf of Australian radiographers who go back to work part-time after having children.

In a funny and furious presentation, coincidentally delivered on Mother’s Day at #ASMIRT2024, Sally Bellchambers, a senior radiographer at Garran Medical Imaging who also works as a casual radiographer at North Canberra Hospital, outlined a troubling journey of inequity and discrimination in her work following the birth of her three children.

“To say my career stalled would be incorrect,” she said. “It went into reverse, I was demoted, denied and demoralised.”

Bellchambers told the Resilience session of the conference that she had enjoyed a strong upwards career trajectory after graduating. But that all changed after she had kids.

She hit multiple obstacles, including being told there was no question, as a part-timer, she could maintain her previous managerial role.

Did she think the world owed her special consideration because she made the conscious decision to procreate?, Bellchambers asked rhetorically.

“No, but I do hold the crazy notion that I shouldn’t be punished for it either,” she said, noting that of Australia’s 18,723 practising radiographers, 69 percent were women and one-third worked part-time.

She has since been able to regain “some of the professional status that I had earnt and deserved”.

But the experience rankled on a wider structural level. Ahead of the ASMIRT conference, she surveyed others working in radiography across Australia, receiving nearly 100 responses, 89 percent of which were from women, the majority working in public hospitals.

Many also reported that they felt part-time employees were undervalued at work, had felt less respected as part-timers, and felt their part-time status meant they didn’t stand a chance of promotion.
Bellchambers told the session she hadn’t decided whether it was “ironic, symbolic or just a little bit bonkers that it’s Mother’s Day and instead of having breakfast in bed and cuddles, I am here speaking about the likelihood that motherhood, while absolutely a choice and privilege, remains a shackle on the majority of those hoping to maintain upward career trajectory”.

Closing her presentation to strong applause, she urged delegates to take back to their workplaces some key points, including:

- Do not discount part-time colleagues: part time is not code for giving up, it is not a participation award, we are not space fillers.

- Parental leave does not signal giving up career aspirations, women have babies not lobotomies…

Sally Bellchambers with her family, from L: Harper, Lily, Teddy, and Jay. Photo provided.

3. Dealing with imposter syndrome

Professor Gill Harrison says she could deliver her presentation on ‘imposter syndrome’ at pretty much every occupational conference around the globe, such is its prevalence in the workforce, regardless of gender or background.

But working to defeat the debilitating mindset is particularly important for her own radiography profession, she said.

“I think a lot of radiographers undersell their skills and abilities,” she told Croakey at #ASMIRT2024 after presenting a workshop on ‘working with your imposter voice’.

“We’re not good as a profession at going out and shouting what we can do and what we do and how good we are. I really want to empower radiographers and student radiographers and sonographers to go out there and say…we can do this!” she said.
Harrison brings an impressive pedigree. An experienced UK sonographer/radiographer, she is currently Professional Officer (Ultrasound) at the Society and College of Radiographers and a Principal Fellow of the Higher Education Academy (PFHEA). She has worked globally, including in Uganda and co-led on the development of standards for sonographic education.

Yet, she said, the imposter syndrome, or phenomenon as she calls it, is certainly something she has experienced “a lot over the years” — as do others, she said, citing studies that show probably 60-70 percent of adults have imposter thoughts from time to time.

Original investigations of the concept focused on high achieving women, but the research now suggests it can impact anybody, and tends to get worse at key moments, such as shifting from being a student to newly qualified or to a new role, she said.

“That’s when it kicks in for a lot of people, but some people feel it most of the time.”

As well as being distressing and stressful at a personal level, having imposter thoughts can have negative effects professionally: some may become perfectionists, or people pleasing, to the detriment of their own health and wellbeing; they may self-sabotage, not applying for jobs or promotions; or they may become micro-managers who are hard to work with.

Harrison offered some strategies to address imposter thinking and underscored the importance when talking about advanced practice, saying that professional stream in the UK is not just about being an expert clinical practitioner, but about “being holistic in terms of research, education, audit and being a good leader, so you need the confidence to bring people with you.”

Also, follow @UltrasoundPG on X/Twitter to see her fantastic photography, including from ASMIRT2024.
4. Imaging children with cancer or violent injuries takes a big toll

Performing medical radiation scans on children who have cancer or have been injured through abuse or neglect can result in significant emotional toll for the paediatric medical imaging workforce, research has found.

Queensland Children’s Hospital paediatric radiographer Fiona Franklin presented at ASMIRT on her Master’s thesis which asked: Are any of the multidisciplinary members of this paediatric medical imaging department struggling with their mental health and wellbeing? If so, what can be done to help?

In 2021, Franklin invited 146 members of her department to participate in the research: 35 surveys were completed, a 24 percent response rate, and then analysed using the Jarden Me, We, Us Framework.

A resounding 80 percent of the survey respondents reported that they had observed an incidence where occupational wellbeing was affected by work, with ‘intense workload’ emerging from the data as one of the key themes.

That intensity takes many forms, her thesis says, but paediatric abuse and suffering was one of the main sub-themes, prompting comments such as:

- ‘Disturbing injuries to children can impact staff by being quite traumatic to see (eg non accidental injury cases)’
- ‘Distressing patient stories’
- ‘It can be very challenging and upsetting when imaging very young children with poor prognostic cancers’
- ‘Also patients who remind you of your children can be upsetting in terms of triggering if your child is affected by a similar illness/disability’.
Drawing on other research, Franklin said that non accidental injury is an area of paediatric imaging that can have psychological repercussions for radiographers due to the traumatic nature of the child’s injuries, the associated legal implications for the parents or carers, and the need to maintain professionalism and non-judgmental attitudes towards parents or carers.

Franklin put forward a number of recommendations for dealing with these pressures, including debriefs after traumatic or difficult work, acknowledgement by the workplace of the complexity and intensity of these issues, review of staffing levels, team workload and management expectations, involving staff in decisions, and having occupational wellbeing as a standing agenda item for team meetings.

She also put the case for supporting employee wellbeing is important, including that happier employees are healthier, have fewer sick days, are more productive, and stay in their jobs longer. By contrast, quality of patient care decreases when staff wellbeing decreased, she said.

Franklin highlighted this US study: ‘Walk in my shoes’: intradepartmental role shadowing to increase workplace collegiality and wellness in a large pediatric radiology department.

5. Neurodivergence is different, not less

Like so many healthcare settings, medical radiation environments are often fast-paced, stressful, noisy and with bright lights.

That can make them challenging for anyone working or learning in them, but particularly so for people who are neurodiverse, says radiation therapist Bernadette Byrne, a clinical educator with the Tasmanian Health Department’s Northern Cancer Service in Launceston.

Byrne delivered a workshop and presentation to #ASMIRT2024 on the need to look at how medical radiation sciences can provide a more supportive learning environment for students who live with neurodiverse conditions during clinical placement.
An estimated 15-20 percent of Australians are neurodiverse, meaning they have a brain that functions differently to what is considered “typical”, she said. Neurodiverse conditions include autism, dyslexia, and attention deficit hyperactivity disorder (ADHD).

Yet, there is “scant research” in the medical radiation discipline about neurodiversity, despite it having been defined as a concept for 30 years now, she said. A UK publication last year asked: How can we support those we know nothing about? Leading on and advocating for more research to support neurodivergent student radiographers in the UK.

Byrne told the conference she came to the issue with lived experience: after a difficult diagnostic journey, both she and her son had been diagnosed with ADHD.

Medication has been “life altering”, but “pills don’t teach skills” and she has put in place many arrangements, including reminders and alarms, to help manage the condition.

It got her thinking about how many of her radiography students, and others elsewhere, have been managing it, diagnosed and undiagnosed, while on clinical placement.

Byrne said medical radiation professionals require a distinct skillset, combining physics, anatomy, physiology, patient care and communication, with ever increasing demands of technological skills.

Awareness of neurodiversity is growing but, in the medical radiation sciences, “is not something we address as part of diversity and inclusion programs”.

“Particularly in our hospitals and clinical centres…it’s busy, everyone is running a million miles an hour, and the impact that can have on a neurodiverse individual, whether patient student or worker, is quite significant,” she later told Croakey.

Stigma and exclusion meant that students would be likely reluctant to ask clinical supervisors, who may well be potential employers, for learning and assessment accommodations.

So the prerogative must be on the profession to understand that “all our learners, neurodivergent or not, have different needs for their placement experiences to be successful and fulfilling”.

Meeting those needs for neurodivergent students, she said, requires looking at how to apply neuro supporting practice, along with universal design for learning to work spaces, looking at a range of factors from adjustable lighting and acoustic settings to providing different methods of written and visual communication.
Watch this interview with Bernadette Byrne

Also presenting at the workshop session was Byrne’s colleague Katie Scott, who discussed gender diversity in medical radiation practice, recommending these two sites: [https://www.seattlechildrens.org/healthcare-professionals/provider-news/gender-inclusivity-toolkit/](https://www.seattlechildrens.org/healthcare-professionals/provider-news/gender-inclusivity-toolkit/) and [https://www.transhub.org.au/](https://www.transhub.org.au/)

Also readers might be interested in this video on ADHD in the workplace.

See [this X/Twitter summary](https://x.com/CroakeyNews/status/1788472354424930343) from the workshop.
6. The keys to a thriving career, workplace and profession

Dr Caroline Wright was this year’s ASMIRT winner of the Varian Award, honouring high achievement in radiation therapy through recognising significant contributions to the profession, patient care, and ASMIRT.

Titled ‘Beyond survival’, her address at #ASMIRT2024 looked at how to establish a thriving (versus just surviving) career, workplace and profession.

Much of the medical radiation sciences’ focus to date had been on patient care, she said, but it was time also to turn the mirror on the profession too.

Also reflecting on self-care and echoing other presentations, Wright admitted it had only been in recent months, after decades in the profession, that she had felt like she was thriving — her self-diagnosis on what had prevented that earlier was that she’d had her fingers in too many pies.

It has only been recently that she has felt able to relinquish certain roles that had previously defined her professionally, without thinking she was a ‘failure’ because she couldn’t manage everything.

“Saying yes to everything is fantastic … but it’s not always the best thing for you,” she said.

Wright mapped out the recent evolution of the profession, including important shifts from cultural ‘competence’ through to ‘safety’ and on to ‘humility’, the growing role of artificial intelligence, and growing awareness of global issues that impact on the profession, including climate change.

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**Where are we now?**

- Post COVID world
- Patient centred care
- Interprofessional collaboration
- Cultural safety
- Professional identity development
- Post graduate courses + research degrees
- Workforce challenges
- Student placement poverty
- Attrition in courses and the profession
- Digital health
- Greater use of AI
- Technology, technology, technology
7. Snapshots from other presentations

Resilience and perseverance – how to balance being a radiographer and a researcher — and some tips for students.

See this summary on X/Twitter.
On thriving, personally and professionally. Some wide-ranging advice from experts at ASMIRT2024

Q5. What is a fake home tip that you would like to share with the 1st year students?

- Gut to know your patients – ask questions
- Take opportunities they give you even if you’re scared (eg. image matching)... if the student keeps saying no to opportunities, they will stop giving them to you
- You’re not alone, if you don’t get it, then others probably don’t either – work together (academic and clinical)
- Use SWOTVAC work to come in and study with and quiz each other – make it fun (you’ll learn it better)
- Have fun on placements – don’t just rote learn it all, relax, focus on understanding why you’re doing it (stabilise, immobilise, reproduce).
- It’s not a role learn course, there are steps, but more to it

See this summary on X/Twitter.

On thriving, personally and professionally. Some wide-ranging advice from experts at ASMIRT2024

"We learnt by watching and listening, waiting and then acting". Dr Mirlam-Rose Ungunmerr-Baumann, quoted at #ASMIRT by Julie Burberry in her presentation on: Yarning Groups; building community within undergraduate Therapy students
Does simulation training adequately prepare us for CPR in the real world?

CPR in the real world – Does simulation training adequately prepare us?
Robyn Holmes talking about the experiences, after more than 20 years in the radiography profession, of having to perform CPR, both in the community and in a hospital setting. #ASMIRT2024

SUMMARY

- Training and simulation training are valuable tools for teaching the theory of CPR
- Nothing can completely prepare you for the real thing
- CPR is a rapidly evolving situation – many decisions are made “on the run”
- Check your mental health and recognise signs that you need help
- It’s okay to ask for help
- Debrief is important
- Doesn’t need to be an official debrief – find a trusted friend or colleague
- Support one another
And that’s a wrap!

See this summary on X/Twitter from the closing ceremony.

Watch this video interview with #ASMIRT2024’s Northern Territory co-convenors Kim Haywood and Bec Kilday.
And that’s a wrap! We hope #ASMIRT2024 exceeded your expectations, inspired your work and research, and helped connect you to the broader MRS community. Thank you for joining us on beautiful Larrakia country - we’ll see you next year in Adelaide!
You can track Croakey's coverage of the conference [here](#).

#ASMIRT2024 Twitter Analytics

A Tweetbinder analysis shows 948 posts used the #ASMIRT2024 hashtag between April and June 2024, with most activity occurring immediately before, during and after the conference. The report shows there were 78 contributors at the hashtag, with a potential audience reach for conference posts of 280,223. Tweetbinder put the value of the hashtag at approximately $25,500.

As well as publishing the series of articles at Croakey.org, the #ASMIRT2024 coverage involved a sustained presence across social media platforms, especially Twitter.

See the full Tweetbinder report [here](#).

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The Croakey Conference News Service team for #ASMIRT2024 was:

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