

The Impact of One

There are many inspirational people in the world of medicine who shape the way we think about our purpose and deeply influence the way we work. Among them is Dr Dinesh Palipana OAM; a genuine changemaker with first-hand insight into both the shortcomings and areas of promise in medicine. I had the privilege of speaking with Dr Palipana in a candid and honest discussion about purpose, perspective, person-centred and value-based medicine, and the potential impact of one.

Dr Dinesh Palipana OAM

- Doctor, Lawyer, Emergency clinician, Disability advocate, Researcher, Author

Downtime hobbies: The Simpsons, driving the dream car, ice-cream

Favourite books: The Daily Stoic (Ryan Holiday), The Diamond Cutter (Lama Christie McNally, Michael Roach)

Favourite superhero: Superman

Fun fact: Shares a birthday with Superman

Travel aspiration: Space

N: Thank you for sitting with me, Dinesh. You've got a full schedule and your attention is divided across multiple fronts. What keeps you going?

D: I truly believe that "He who has a why to live can bear almost any how."

So it's really about having purpose.

I came to medical school after doing law. I had depression and I saw a doctor for this. He really inspired me to become a doctor myself.

I love this [medicine]. It's the best job in the world. And it's amazing.

So that's what has kept me going. I believe purpose is really important for a human being.

N: What do you hope future individuals living with disabilities will be able to think, do, and feel?

D: I just want them to feel like a human being. You know, as we all do inside, right?

We have had a history of being a very divided society. And there's certainly a lot of conflict happening all around the world today. Even today, there are many parts of our society where people are very much divided. But I do believe that more and more, we're seeing that labels don't matter as much. I hope this change stays around and I hope that we won't be having to have these conversations about labels.

N: Touching on labels for a second, some people see their pre-injury life and their post-injury life as two separate parts, and their entire life narrative revolves around that. Do you see your life in two parts? Do you have labels for good and bad events in life?

D: There's a book called, The Diamond Cutter, where the author likens the events that happen to us to a diamond - when you take a diamond out of the ground, it's just a rock.

But he says that if you cut it, and then make a princess cut or whatever-other cut, and you hold it up in this light, it's beautiful and incredibly valuable.

He says that the events that happen in our life are like a diamond; we can attach whatever meaning to it that we want. And we can shape it into whatever we want.

So I've taken that approach to life. Nothing is good or bad until we attach a good or bad label to it.

Did this [injury] happen to me? I can't change what happened, right? And so there's a lot of good that came out of it. You and I are having this conversation right now.

So I don't think that it's bad. I think it's given me opportunities to live life differently, and hopefully become a better person.

N: What's something in your sphere that you're particularly passionate about at this point in time? Maybe something at the cutting-edge?

D: So we've got our own project, right? And so we're hopeful.

But I think it's dangerous to become tunnel-visioned in anything.

I think one of the best examples of this is that historically, we have believed that stem cells are the answer [for spinal cord injury]. But a lot of the data and a lot of the studies so far have not been that promising. But I think our dogma is still so strong that we're like, "well, you have to fix this".

And also we think, "Okay, if we don't grow new stuff, how's it going to work again? But I think this is too simplistic a view of the central nervous system - and we're probably not thinking about it correctly.

By the way, I think this is all the area that rehab medicine needs to do. It needs to do more.

N: Absolutely, rehab really could be leading the way with spinal cord injury research. Touching on advocacy now - because you are playing that role for many people who aren't able to speak up for themselves. Who did you have in your corner that a lot of people don't have and are struggling for it?

D: A lot of people. But my mum has been the biggest. My mum, and there's been some doctors and academics that have helped me along the way.

I love the belief that the only thing necessary for bad things to happen is for people to do nothing.

But we do live in a world where everyone is so afraid to be bold and be courageous, too.

They're worried about their jobs or their reputation. We need people that just have boldness.

N: A lot of people reading this right now will be in the world of rehabilitation. How can the rehab professional, whether they're a doctor or not, make a difference by what they do and say to someone who's newly entering a life of disability?

D: I love these kinds of questions. So, one of the best experiences I've had with a doctor was someone who was in the ambulance with me.

The thing I take away from that experience is that I don't actually remember any of the things that he did. I couldn't tell you what analgesia he used, I couldn't tell you whether I had a hard collar on or not.

I don't know. I don't remember any of that.

But I can tell you what he told me. I can tell you the words he used, the tone he used, the warmth, the expressions he had. I can tell you how I felt as a result. And what he taught me is that people may not remember what we do, but they'll always remember how we made them feel.

So, I think we have the potential to do an incredible amount of damage to our patients. And that's not just detrimental to the patient. It's also detrimental to our profession.

I think trust in us [medical professionals] has been eroded. And that's because of our attitudes towards people.

So, I think the biggest opportunities that we have, especially in rehabilitation medicine, is to make that impact on someone - where they can take care of themselves, and where they can live life to the fullest. We live in 2024, anything is possible.

"All it takes is one person."

My mom, she says that. And I quote her all the time, "By helping one person, we might not change the world, but we will change the world for them."

I think that's the power of medicine. It's the power of being a doctor.

I think that rehab medicine in particular, I mean you're seeing people whose worlds are falling apart – spinal cord injury, stroke, whatever it might be.

So whether it's a rehab physician, physiotherapist, occupational therapist, or whoever it might be, the rehab world has the biggest opportunity at reaching someone.

N: So in order to allow all of this to happen on the ground, the health system needs to facilitate that, and allow for that [good patient care] to happen at the bedside. Where do you see the cracks in the rehab system that disallows really good patient care from happening at the bedside?

D: Paternalism, I think.

We always assume that we know what's good for a patient. But we don't. It's been said that our job as a doctor is not to treat a disease that a person has, but to treat a person who has a disease.

I think we have to take the whole of the patient, and we have to figure out what's important to them. You know, a lot of the time people ask me, "Why don't you feed yourself?" Which I often don't, and it's a matter of efficiency. My mum helps me or someone else with me might help me.

Because I can eat quicker and get back to work, cutting up the food myself is not as important to me as getting back to work, and doing my job.

So I think it's about figuring out what's actually important to the patient.

N: Essentially not making assumptions about the person?

D: Exactly. But it's also that when I get home, it's time for me and my mum to spend some time together.

So you know, it's this sort of thing. I think it's really about putting the person first and using our resources and knowledge to do that well.

One of the biggest dangers is that we're too paternalistic and too prescriptive about what the patient wants.

Secondly, I think the physical environments really matter, particularly in rehabilitation. Because you have someone for months at a time and their lives have changed drastically. Good physical environments make a massive difference.

And thirdly, just kindness. Kindness.

N: Is that [kindness] still lacking?

D: Sometimes. I've experienced some places where sometimes they just storm in like, "Okay, time for you to shower", and suddenly you're off somewhere, not knowing what's happening.

So simple things like that really matter. And I understand that we have to balance that with the demand of the hospital, and the system, and the structure. But I think in rehab in particular, we need to be able to shift some of those structures.

N: If we can't shift these in rehab, where are we going to shift it, right?

D: Yes, and we'll have to be appropriately resourced to do that.

N: Where did you draw your inspiration when you were absolutely going through the worst days [in rehab]?

D: My mum, she was a big one. Having people like my mum who loved me was really great.

But I often think about this - I was born in Sri Lanka, which used to be called Serendip; meaning Serendipity. I often think that my life has been serendipitous in a way.

We lived through a war in Sri Lanka. We already saw a lot of hardship and got a lot of perspective. We had already seen death and violence.

I've been through depression before the injury happened.

So I think all those things set me up to have a bit more perspective and strength. And I think that having a "why" really helped as well.

I actually really wanted to become a doctor again. Really wanted to get back to life.

N: It's really clear that you've taken it all in your stride. You've got resilience and you're also ready to keep going further. I wanted to go into the broader sphere again – how do you think we're going with addressing health equity in rural and remote communities?

D: There are some deep-rooted challenges in communities. There are communities that are nearly completely isolated in various areas of Australia and we find it really hard to reach into them.

N: Is that why you joined ACRRM?

D: Partly, yes. And it actually goes back to the root of why I wanted to be a doctor.

ACRRM trains this skill set of going anywhere and doing medicine, which I really love. But I mean, there are communities all around Australia that are insulated. And there are nuances in those communities.

For example, looking at the community that my parents came from, there are taboos and there are issues that are very nuanced in those communities. So it's actually very hard to dig into these deeply-rooted issues.

N: Where might we start?

D: We just start one at a time. If we look at a big problem as a whole, it often seems too difficult to shift.

But if we think about parts of it – perhaps it might be looking at a hard-to-reach community and seeing how we can provide rehab services better.

Or it might be about figuring out how we communicate better with a patient that doesn't speak English. How do we better have translator services and culturally sensitive services?

I think these sorts of things are not just a nice thing to do, but it makes medicine more efficient. Gives people better outcomes.

A lot of problems have people thinking, "someone must be doing that"; or, "someone must be working on that."

It takes someone to ask, "is someone working on this? Could that someone be me?"

It just takes people to actually start and to do something. To try, and fail.

It's okay to fail - because you need to figure out what doesn't work.

But we just need to start doing something.

N: Onto the structures and systems around us right now, what are your thoughts on the positive and not-so-positive sides of the NDIS?

D: I think the NDIS is amazing. We have shifted life for people with disabilities in this country. It's a beacon for the rest of the world. It's unique.

But I think the problem is that there are a lot of people attempting to exploit the NDIS - and people with disabilities - financially.

So I think that's the only problem with the NDIS that we need to figure out.

And again, making sure that it [the NDIS] serves the needs of the people that are needing it the most.

I don't think a lot of this is about more money. I think it's about efficiency.

N: You're working with BioSpine, and there's a lot happening in the rehabilitation technology world. You also wrote a paper recently on co-design in rehab tech. Tell us a bit about that.

We were at a time 20 years ago where technology limited our imagination; we just didn't have the processing power or the tools. But now, our imagination limits technology.

There is so much technology right now. So we're at a time when the technology is there and if we in medicine don't keep up, I think we're going to be left behind.

Co-design is really important because otherwise we're going to be developing solutions that aren't fit for purpose.

Unless you ask the question, you won't know what challenges the person is experiencing, or what's important to them. Again, we often wrongly assume we know what the person wants.

N: Touching on rehab abroad and across the world - a lot of places are struggling a lot, much more than we are in Australia with our particular struggles. Where do you see the current frontiers in terms of living with a disability in a developing country?

D: I think there are probably 3 points on this.

One is changing societal attitudes. In many countries, there are taboos around disabilities and medical conditions - like spinal cord injury. And they're far more pronounced than in this country.

The perceived worth of the life of someone with a disability is different. And that affects everything - their quality of life, work, education, everything.

The second challenge is actually knowledge and skills. Rehab medicine as a specialty, and even emergency medicine as a specialty, is still not around in every country.

So it's about equipping these places with knowledge - and allied health - many countries just don't have these resources. So it's about developing those disciplines.

Thirdly, it'll be about developing cost-effective solutions. So with BioSpine, we're working on spinal stimulators - but we're also making an open-source one.

We want it to be a few hundred dollars and easily usable.

We've got these examples of countries receiving donated CT scanners, and the people at the hospital are like, "Great, how do we use it? How do we repair it? Who maintains it?".

So we need these tools to be available as freely and easily as possible. It's an issue of economic disparity.

N: Great insights and thank you very much for chatting with me, Dinesh.

D: Absolutely, my pleasure.

N: Can we grab a photo?

D: Yes, I insist.



*An interview with Drs Dinesh Palipana OAM, Nathaniel Chandra
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