medicSA
AUGUST 2020 VOLUME 33 NUMBER 4

# Care factor

## Leading the AMA through the pandemic

AMA SOUTH AUSTRALIA

AMA'S NEW LEADERSHIP TEAM • MANAGING COVID-19 IN RURAL SA
FEEDING THE PLANET • HEALING HANDS • VALE SENIOR MEMBERS


# Specialist radiology services in the Adelaide CBD

DR JONES & PARTNERS MEDICAL IMAGING

Calvary Adelaide Hospital is the largest private medical imaging clinic in South Australia and offers a comprehensive range of specialist radiology services without comparison.

The clinic boasts a Siemens Vida 3.0T MRI and a Siemens Sola 1.5T MRI which compliments the low dose CT, X-ray, Ultrasound, Interventional Radiology, Nuclear Medicine and Dental Imaging capability. All are designed to deliver the highest quality diagnostic / interventional radiology services whilst providing the best patient experience in the heart of the Adelaide CBD.

Our commitment to this clinic and our referrers is to invest heavily in our staff and our sub-specialised Radiologist team to promptly arrange the diagnosis and appropriate management of your patients. Aligned with the needs of the hospital, the clinic has a strong focus, but not limited to Neurology, Spinal, Orthopaedic, Interventional, body and Emergency Imaging.

**We look forward to working together with you to deliver the best possible medical imaging services for you and your patients.**

**drjones.com.au/calvary-adelaide-hospital**

**+ 7 Day Service**
**+ Weekend Reporting**
**+ Walk-In Services (CT/X-ray)**
**+ After Hours Appointments**


**Dr Nicholas Bajic**
Clinic Director,
Calvary Adelaide

drjones.com.au/**online-referring**

**Australian Medical Association (South Australia) Inc.**
Level 1, 175 Fullarton Road,
Dulwich SA 5065
PO Box 134 North Adelaide SA 5006

Telephone: (08) 8361 0100
Facsimile: (08) 8361 0199
Email: medicsa@amasa.org.au
Website: www.amasa.org.au

**Executive contacts**
**President**
Dr Chris Moy: president@amasa.org.au

**medicSA**

**Editorial**
Editor: Dr Philip Harding
Managing Editor: Karen Phillips

**Cover image**
Brett Sheridan, Blue Razoo

**Advertising**
medicSA@amasa.org.au

**Production**
Typeset and printed for the AMA(SA) by Douglas Press Pty Ltd.
ISSN 1447-9255 (Print)
ISSN 2209-0096 (Digital)



# Contents




## What's next?

While AMA(SA) colleagues, family and friends gathered elsewhere – at COVID-acceptable distances – AMA(SA) President Dr Chris Moy took a few moments to prepare for his vice-presidential candidate's speech during the National Conference on 1 August. Soon, Dr Moy would be elected Federal Vice President alongside new President Dr Omar Khorshid, becoming the first South Australian to hold the national VP office since Dr Trevor Mudge from 2000 to 2003.

# Is your practice covered for employment disputes?

Employment disputes are more common than you think.

At Avant, we've helped practices overcome disputes with or between staff, issues relating to employees' use of social media and contractual arrangements.

These employment issues can significantly affect the performance of your business, so it's important your practice has the right protection and support to minimise their impact.

Avant Practice Medical Indemnity Insurance covers the legal costs to defend a claim against your practice. Our expert medico-legal team is also here to provide tailored advice so you can prevent disputes from escalating in the first instance.

**Employment disputes can significantly affect your business. Make sure your practice is covered with Avant Practice Medical Indemnity Insurance.**

---

**Avant Practice.** By doctors, for doctors.

**1800 128 268**

**avant.org.au/practices**

Avant mutual
by doctors for doctors

President's report

Dr Chris Moy

# Strange days are these

As I write this, we in South Australia can but feel like we are living in a safe parallel universe when compared to our Victorian brothers and sisters.

Leaving to one side the causes of the second wave of COVID-19 infections which have struck Victoria, what is not in dispute is the frightening rapidity in which it developed and how quickly it took health services to the brink, as well as overwhelming testing and contact tracing capabilities. There was almost universal alarm at the handling of the escalating situation by the Victorian Government, which was putting not only the Victorian community at risk, but the rest of Australia as well. However, this was not voiced publicly by many authorities due to a need to maintain the appearance of cohesion which has served Australia well so far in the pandemic.

This is where the independence of the AMA became important in recent weeks, as it became essential to articulate to the public the seriousness of the situation and the need for Victorian authorities to move quickly to a much higher level of lockdown. AMA(SA) provided support to our AMA Victoria colleagues including in using our media influence, culminating in an interview on national television where I explained that it was 'now or never' for Victoria to move to Level 4 restrictions because 'finicking around' had not worked and was risking the rest of the country. Within days of a concerted media effort by the entire AMA, Victoria moved to Level 4 restrictions.

Our independence, and our willingness to stand up when it is required for patients and colleagues, seems to me to be at the core of why the AMA has the trust of the community.

It was the need to reinforce this independence, during the pandemic and beyond, that was a major reason I nominated for the position of AMA Vice President alongside my friend and former AMA Western Australia President, Dr Omar Khorshid. It was a strange campaign; Omar and I didn't meet in person once during our months of preparation. And it was an equally strange AMA National Conference, with delegates sprinkled across our nation connected via technology and computer screens. But we were fortunate that our shared vision for a better, stronger, more approachable and inclusive AMA seemed to strike a chord with delegates across the country, so that Omar and I were successful in our respective elections at the National Conference on 1 August. I am pleased that we can now begin the work we promised would be the focus of our efforts. We want to advocate for all AMA members, and can only do that if we hear from you. I'll be doing my best to support Omar in leading your AMA. I hope you'll let me know how to do it better as we go along.

I would like to thank the AMA(SA) Council and Executive Board, South Australian delegates, the AMA(SA) secretariat and our wonderful CEO Dr Samantha Mead for their support these past months.

Meanwhile, I will continue in my role as President of the AMA in this state. This role is as important to me as the national one and I have been so fortunate to have presided at a time when I have been able to see how you, our members, have contributed so much to the recent efforts in South Australia. Although a great deal of uncertainty remains regarding the course of the COVID pandemic, what I am certain about is that the community can continue to rely on their doctors and our profession to be there for them.

*… our shared vision for a better, stronger, more approachable and inclusive AMA seemed to strike a chord with delegates across the country …*

# Brain tumour masquerading as an IT problem

Former AMA(SA) President Dr Philip Harding discovered the hard way that a brain tumour is one of the problems that can't be fixed by turning the computer off and on again.

*Dr Philip Harding pictured at the AMA Federal Election gathering at AMA(SA) offices at Fullarton on 1 August*

When I wrote my editorial column for our first online edition in June, specifically on the subject of the new Calvary Adelaide Hospital and the way in which it had acquired and then lost its original name of Wakefield Hospital, I had no idea that within a few weeks I would be lying within this new institution as a patient with a serious medical emergency. The unusual way in which this presented is worthy of documentation.

I have been a very long-term user of voice recognition technology in the form of Dragon Dictate, also known as NaturallySpeaking, and use it for everything I write, including what you're reading at the moment. In early 2019 I re-equipped my office with a new desktop system and upgraded the Dragon to professional version 15. This was a huge overnight download from Dragon's US base, accompanied by a long online tutorial from one of its expert technicians, as I recall from somewhere in the depths of Minnesota. There were some differences from the version 11 I had previously but the system generally worked well.

Sometime in about March this year I began to experience inaccuracy with the voice recognition. Those familiar with these systems will be aware that the program has to be trained to the voice of the specific user. The accuracy problems persisted despite my contacting the Dragon agent in Sydney who suggested some simple fixes in the program settings. These made some difference but not to a satisfactory extent. I could not come up with a solution and became quite frustrated with the poor performance of Dragon, which has for a long time been such an essential tool with all my computer work, particularly as I am a hopeless typist.

Then, on May 14, a day of which I have no recollection, my wife noticed that on rising I was unsteady and that my speech was particularly slurred. She thought I was developing a stroke and despite my protestations called the emergency ambulance. The crew agreed with her assessment and conveyed me to the new RAH, where a CT scan showed a mass in the right temporal region with significant associated cerebral oedema and midline shift. I was transferred to Calvary Adelaide under neurosurgical care. Partial resection of the lesion, which turned out to be a high-grade glioblastoma, was undertaken that evening.

The surgical decompression and associated high-dose steroid therapy rapidly relieved the cerebral oedema and reversed the midline shift, and clinical improvement began to occur. On initial presentation at the new RAH I was observed to have a left hemiparesis, which did not persist, and was also found to have been aphasic. As I'm right-handed, this latter finding would have been inconsistent with the non-dominant site of the lesion, and it was agreed with the neurosurgeon that what was being observed was a relatively severe dysarthria.

After a few days in the neurosurgical ward I was transferred to the rehabilitation ward on site at Calvary Adelaide and commenced an active program including quite intensive physiotherapy, speech pathology and occupational therapy. On day 23 I was discharged home to continue these activities under the supervision of the Rehabilitation in the Home program (RITH), a public-sector program operating from the Queen Elizabeth Hospital that supplies home visits from the above-mentioned allied health professionals. The speech pathology was particularly effective; both the professionals and my family and friends noticed that I was speaking much more clearly. Associated with this, the Dragon NaturallySpeaking program now works perfectly. There had been no problem with the software: the dysarthria presumed to be an effect of the developing tumour and consistent with its location in the right (non-dominant) temporal area prevented the program from recognising my speech correctly.

By this stage a definitive treatment program had been agreed, following discussion of the relevant clinical trial data, involving an intensive three-week protocol of daily Monday-Friday radiotherapy sessions and simultaneous oral chemotherapy using temozolomide, to be followed by an adjunctive phase of six cycles five day/28 days temozolomide. The three-week program that started when I returned home was well tolerated with minimal side effects; the worst was fatigue attributable to the radiotherapy. At the time of writing - day 46 from initial presentation - I am having a rest from all treatment pending a major review with imaging at the end of July, which will act as a baseline for further follow-up and possible active treatment.

A thought that has been wandering around in what remains of my mind has been why I should develop such a problem with its uncertain prognosis, having been fortunate to avoid most of the shafts and arrows of life during almost 80 years of healthy life. My only other significant 'other side of the sheet' episode was an aortic valve replacement conducted successfully (and coincidently in Calvary's predecessor Wakefield Hospital) in 2014.

Just about the time the emergency situation occurred in mid-May, ABC television started screening *Operation Buffalo*, a semi-documentary series depicting the series of British atomic bomb tests at Maralinga and nearby areas in far-west South Australia in the 1950s. This was a very controversial event, the British government knowingly allowing significant Australian servicemen and the local indigenous people to be exposed to radiation. I enjoyed watching the series - mostly while in hospital - as I felt connected with it in two ways. First, as a teenager growing up in Salisbury North at the time these tests were conducted, I had several friends whose families were British expatriates involved with the test program. Second, in 1967 as part of my military service, I was senior medical officer at RAAF Edinburgh and the remaining skeleton facilities at Maralinga were part of my administrative responsibility.

On one occasion I gave the civilian doctor in charge at Maralinga a weekend off and went up there to relieve him. It was an interesting weekend in a number of ways but one of the things I did was to go out to Emu Field, which had been the site of one of the major tests, and stand on the spot where it went off, identified by the marker depicted here and showing warnings about persisting radiation levels. I do remember wondering whether all the excitement was really such a good idea. And sometime in the past few weeks I related this story to my brother, who also has a history as a RAAF medical officer. He commented, 'I wonder how many people who did that stupid thing now have brain tumours?'.

Food for thought, perhaps.


*A marker at the Emu Field test site at Maralinga*

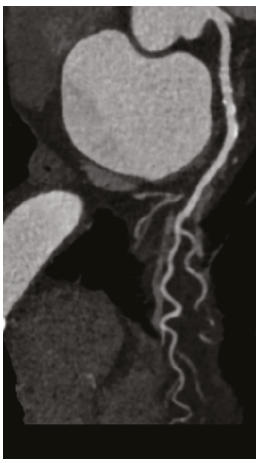
radiology SA

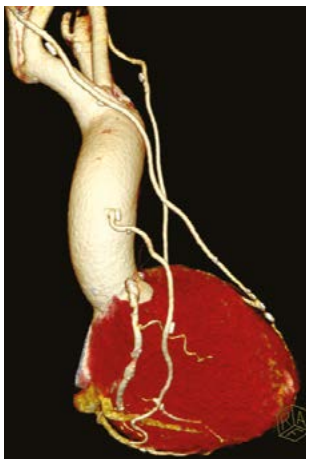
# Latest in Cardiac Imaging

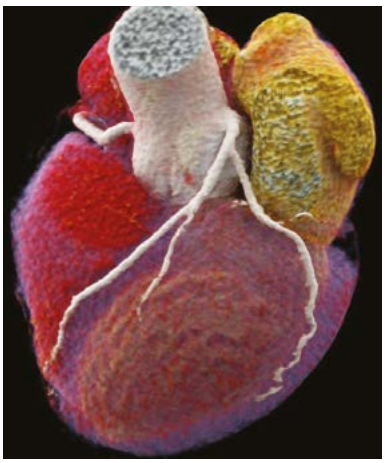

**Coronary CT Angiography [CTCA]**

**Coronary Arterial Calcium Score [CAC]**

## Comprehensive imaging with the latest technology







## Available at these locations

**Flinders Private Hospital**
1 Flinders Drive
Bedford Park

**Calvary North Adelaide Hospital**
89 Strangways Terrace
North Adelaide

**Calvary Central Districts Hospital**
25-37 Jarvis Road
Elizabeth Vale

Doctor owned South Australian company

www.radiologysa.com.au

# A foundation for growth

The 2020 annual general meeting of AMA(SA) provided a different perspective on new and emerging issues.

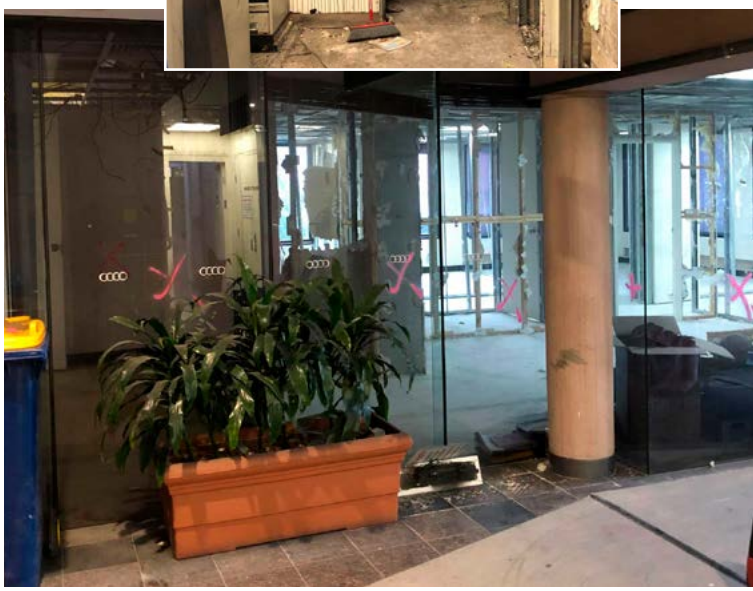
The annual general meeting of the Australian Medical Association in South Australia mirrored so many meetings of 2020, with members of the AMA(SA) Executive Board, Councillors, members and Secretariat staff members 'gathering' in the Zoom meeting on 6 August.

The meeting included the re-elections to the positions of President and Vice-President of incumbents Dr Chris Moy and Dr Michelle Atchison.

While the 2019 Annual Report reflects AMA(SA) activities in 2019, discussion at the AGM included recent challenges that have affected and will continue to dramatically influence the organisation in 2020: the fire at AMA House on 6 May and the resultant move of the Secretariat to temporary premises, and the immeasurable impacts of the pandemic.

Board Chair Dr John Nelson said that despite the 'internal and external challenges' facing AMA(SA) in the past two years, 'somewhat perversely and in a purely financial sense, the outcome is currently positive.'

Dr Moy, who chaired the meeting, said reasons for optimism included the 'exciting' re-organisation of the AMA(SA) Doctors in Training Committee, the restructure of the AMA(SA)CGP, and the medical students' involvement and commitment in responding to the pandemic.



*The AMA House fire will be an issue for the AMA(SA) Executive Board in 2020 and beyond.*



## Dr Danny Byrne
## Councillor

AMA(SA) Council Meeting
August 2020

Council continues to meet via Zoom and I have to say we are all becoming better and better at using the technology and remembering to 'unmute' before we speak.

AMA(SA) Council Chair and Vice President Michelle Atchison has introduced a new practice for our Council, opening each meeting with an Acknowledgement to Country spoken in Kaurna language. I personally find it quite moving. Well done to Michelle for making the effort to learn this and put it into practice.

This was the first AMA(SA) Council meeting since the 2020 AMA National Conference at which our SA President Chris Moy was elected Vice President with Dr Omar Khorshid from WA gaining the Presidency. As he cannot hold two spots or have two votes, Chris nominated Doctor in Training representative, Dr Hannah Szewczyk, as his 'proxy' to represent the AMA(SA) on Federal Council, a motion unanimously supported by Council.

Two casual vacancies on Council needed to be filled, with Professor Ted Mah filling the vacant spot representing orthopaedics and Dr Clair Pridmore to represent public hospital doctors. Please make use of your representatives on AMA(SA) Council; we are only too happy to listen to any feedback, concerns or ideas.

COVID-19 is never far from our minds. Dr Moy was able to give an update on the current Victorian situation with a special emphasis on health-care workers' access to appropriate PPE. As Federal Vice President, Chris is now in the thick of representing our front-line health care workers all over Australia. I know he is bringing his enthusiasm, energy and passion to do just that.

One of the most important items on the agenda was to endorse the draft Terms of Reference (ToR) for the Doctors in Training Committee. Hannah and her team have worked hard to modernise the ToR, with a special effort to update the representative structure. The Committee will be more reflective of the 20:20 make-up of our Doctors in Training across the geographic spectrum and the mix of specialities represented.

A final agenda item was to recommend to the AGM that followed this Council meeting to reappoint Pitcher Partners as the auditors for 2020. With COVID-19 and the AMA House fire it was thought important to have continuity and stability in this area of governance.

# Running mates

West Australian surgeon Dr Omar Khorshid and AMA(SA) President Dr Chris Moy were elected as Federal AMA President and Vice President on 1 August. In the weeks leading to the election, Dr Khorshid and Dr Moy released two podcasts in which they explained their perspectives on issues such as why they campaigned on a 'joint ticket' and the role of the AMA during and after the pandemic.

Some of the key questions and their answers (changed for brevity and readability) are provided here.

***What's your vision for the AMA under your leadership?***

***OK:*** My vision is to be the peak medical body. The body that everyone else looks to for direction and for leadership. We have a lot of representative bodies, colleges and associations within our membership – within our profession – and we've also got lots of other really important players in the health system, starting from patients, of course, but also hospitals, private health insurers, governments. And our health system is so complex. We need to bring all those people together to have the big conversations about where we need to take health to deal with the challenges we know are coming. We do need also to engage with other medical organisations, not compete with them. We want to be the peak medical body, and that means bringing those other organisations together rather than fighting with them. And that's certainly something that I'm committed to do. We really want an AMA that doctors care about, that doctors aspire to be members of, and when they are a member, that it has a meaning to them.

***What has COVID-19 meant for the AMA and its members?***

***OK:*** Right at the start, we saw a lot of fear; we saw uncertainty about how do we even treat patients with this condition? Our members were also affected in more practical ways; not being allowed to operate for surgeons, for instance, meant a complete loss of income for a couple of months. But there have been positive lessons as well; we've learned we can make change really fast.

***CM:*** There's been this can-do attitude, which has really broken through a lot of inertia and resistance that have often held sway in the past.

***There are a lot of doctors facing financial challenges because of the pandemic. How do you think the AMA can help their members with this side of things?***

***OK:*** We need to have our hospitals safe places to work so we can keep treating patients there, even while we've got viral outbreaks in nursing homes or in certain geographic areas. The other thing that's going to be a really big item on our agenda is the financial impact on our whole economy. And we as an AMA need to be ready to lead the profession – whether it's reform ideas, even just bringing people together to discuss the future.

***Part of the role of president of the AMA is advocating for doctors in the media. Recently we learned doctors working in Sydney hospital were being bullied by hospital administrators, simply for asking for protective masks. How would you respond to this?***

***OK:*** We saw this a lot early on during the COVID-19 pandemic, but things have changed. We've now got clear guidelines and we've got a great supply of PPE. No health worker should contract this disease in the course of their work. It's a strong message, really to the hospital administrators, to say: 'You are going to be responsible. You have to provide a safe workplace and you will be responsible if your health workers are not safe in their workplaces'.

***What about the bullying aspect?***

***CM:*** I've been a victim of bullying and I've seen what it looks like, and it's something I feel really needs to go. And I think something like bullying about the mask issue is representative of the fact that the doctors and nurses are not the priority in healthcare. And so, for example, in South Australia, we're trying to embed into legislation that boards have equal responsibility, that is explicit that they have to care for the health and welfare of their staff right up there with caring for patients and managing budgets.

***With the current COVID-19 pandemic, why do you think the AMA's visibility is vital?***

***OK:*** During COVID, we have had an enormous impact as an AMA. Different at a national level to each state, but a lot of collaboration with the government and the big decision makers in government, but also some really strong statements from the AMA in the public from some of our state AMA presidents from our federal president that actually pushed the government to make hard decisions and got the public to realise that actually these decisions are okay if they're needed. And that's what saved us from a huge early outbreak of COVID.

***Can you talk about why you are involved in the AMA?***

***CM:*** What I've found behind the scenes and what people don't realise, is that the organisation has an almost frightening level of influence. Therefore, I understand that there is a need for this organisation to change both practically so that people can get what they need from the organisation, and also in spirit

Dr Omar Khorshid

Dr Chris Moy

so that they can feel more welcomed and so that we can encourage younger members and members who are maybe more diverse in their views to join the fight and become the leaders of the future.

***The AMA is only as strong as its membership, so what will you be doing to encourage retention and entice new members?***

***OK:*** The AMA does an awful amount of hard work for all members, and in fact non-members, all doctors and health in the community. What we're not so good at is explaining that to people, showing them what is being done on their behalf, and we're also not that good at listening. So, I think those are two key issues: working out how to communicate better outwards, and how to accept feedback issues from members. [We need] to change our culture, to be more inclusive and allow people access to our leaders within the AMA, but also use technology to better engage with the broader membership and the broader profession.

***To avoid the AMA being too city-centric, how will you attract doctors from rural and regional areas?***

***CM:*** We need to use technology, number one, and we need to genuinely listen. I think one of the other things is to go visit, not just sit in our ivory towers, but to get out there. [For example] as AMA South Australia president, I had my eyes opened to the needs of those in the country when I visited the west coast of South Australia and saw the real need out there.

***Strategy does sometimes feel a bit remote from members' everyday work, but why is strategy so important for AMA members?***

***OK:*** The strategy of the AMA isn't something the average member should need to think about, but it's a tool we need to use to help us focus on what we are and what we stand for, and to target our efforts to improve the health of Australians. Strategy isn't everything, though. We also need to have the commitment to deliver. We've got to have the passion, the energy, the availability to make sure that we're out in the community being seen by politicians, by patients, and, of course, by doctors.

***What about AMA policy?***

***OK:*** Policy is probably the strength of the AMA. Our whole structure is designed to be a policy factory. We bring together a broad group of people and we develop great policy. Where we sometimes fall down is in implementing that policy. That's really the challenge.

***Why do you want to do this job, Omar?***

***OK:*** The reason I want to do it is it's actually really important. It's one of those opportunities for the AMA to reach out into the community, to build that trust and recognition of our brand and of our profession and the great things that we do. So, it's just got to be done, it's part of the job, and I'm up for it.

***Why is communication so important when it comes down to implementing new strategies and policies?***

***CM:*** This is a membership organisation and we should be representing members, and we need to understand what they have in their minds and hearts. So, we need to be able to listen. And to be able to listen, we firstly have to have the mechanisms to do so. And number two, we need to be able to open our hearts to those ideas and really incorporate the ideas from our members so that they can be generally a part of where we go from here.

***Your elevator pitch: you each have 30 seconds to convince members to vote for you.***

***OK:*** Our profession needs a strong, vibrant, and nimble AMA, especially in these times. Our challenge is to demonstrate our leadership of the profession through active listening, engagement, clear and targeted communication, and by working with government and other stakeholders while also maintaining our independent and trusted advice. I've always been a proud AMA member, and I hope to have the opportunity to transform our AMA into an organisation that all doctors aspire to join.

***CM:*** COVID's showing me that the AMA is fantastic at standing up and getting things done. Now is the time to build on this and to mould the organisation into something that works for members and potential members, and really inspires them to become involved and then to serve and really feel like it is the way that they can change the world for the better.

***Describe yourself in three words.***

***OK:*** Logical, persistent, collaborative.

***CM:*** Direct, positive, and compassionate.

# Support for asylum seekers earns President's Award

AMA ACT President Dr Antonio Di Dio has been presented with the AMA President's Award for his work representing the AMA on the independent panel established to assess the medical evacuation cases of asylum seekers in offshore detention.

*Dr Antono Di Dio*

Dr Di Dio, a Canberra GP, devoted countless hours of his own time as the chair of the Independent Health Assessment Panel (IHAP), which was set up under the Turnbull Government under the Medivac legislation to review the cases of detainees on Manus Island and Nauru.

'At all times, Dr Di Dio undertook his work with IHAP in the best traditions of the medical profession and the AMA, applying his expertise without fear or favour while discharging his duties with care and compassion,' AMA President Dr Tony Bartone said.

'Antonio's IHAP duties required serious statutory obligations, involving his skills as a medical practitioner, and as an officer of the AMA.

'All of this involved an extraordinary call on his personal time, during circumstances that were highly politically charged.

'It is a tribute to Antonio's skill and compassion that he was able to so effectively discharge his duties; a matter that reflects great credit on both him and the AMA.'

Dr Di Dio was presented with the President's Award at the AMA National Conference on 1 August.

# Tasmanians lead Fellows list

Two current State AMA Presidents, two past State Presidents, the *Medical Journal of Australia* editor, and a married couple have been inducted into the AMA Roll of Fellows, in recognition of their outstanding contributions to medicine, the medical profession, and the AMA.

Four of the seven are from Tasmania. The new inductees are:

- AMA Tasmania Past President and anaesthetist Dr Stuart Day
- AMA ACT President and GP Dr Antonio Di Dio
- AMA NSW Immediate Past President and GP Dr Kean-Seng Lim
- AMA Tasmania President and occupational physician Dr Helen McArdle
- *Medical Journal of Australia* editor and neurogastroenterologist Laureate Professor Nicholas Talley
- Tasmanian representative on the AMA Federal Council of General Practice and GP Dr Anne Wilson
- AMA Tasmania State Council representative and GP Dr Don Rose.

Outgoing AMA President, Dr Tony Bartone, announced their addition to the Roll at the AMA National Conference, held via videoconference on Saturday, 1 August.

'These seven outstanding doctors demonstrate the extraordinary range and professionalism of the AMA membership,' Dr Bartone said.

'Dr Anne Wilson and Dr Don Rose have devoted close to 70 years of service to their community in northern Tasmania and to the AMA, while raising a family of four.

'Professor Nick Talley has combined his work as a world-leading neurogastroenterologist with his role as editor of one of the world's most influential medical journals, the *Medical Journal of Australia*.

'Dr Helen McArdle, who last month became the first female President of AMA Tasmania, is a senior medical administrator and an occupational physician, who is committed to diversity and equity within the profession, and to doctors' wellbeing.

'Dr Stuart Day has shown tremendous dedication to the AMA for the past quarter-century, representing hospital doctors and serving in a variety of roles, including as AMA Tasmania President.

'Dr Antonio Di Dio has been the driving force behind the doctors' health service in Canberra, and provided countless hours of his own time to review medical transfer requests for asylum seekers in offshore detention.

'Dr Kean-Seng Lim is committed to providing integrated care, where doctors, nurses, and other health professionals work together for their patients, and helped develop a schools-based obesity prevention program now in use in 24 schools.

'All of these doctors have excelled not just in their medical specialties, but in their roles as advocates for the profession.

'They have made real contributions at the State and Federal level to

improve working conditions for doctors, to improve safety for patients, to train the next generations of medical practitioners, and to make the Australian health system work more effectively for patients and communities.

'I commend them for their service.'

Each new AMA Fellow has an impressive record of achievement, as these edited excerpts from their citations show:

**Dr Stuart Day**

Dr Stuart Day has shown tremendous dedication in his commitment to the AMA and the profession throughout his 24-year membership, holding roles including AMA Tasmania President (2016-2018) and Federal Councillor, as well as more than 10 years as head of Australian Salaried Medical Officers Federation (ASMOF) Tasmania.

He continues to be an active member of the AMA, and is generous in the giving of his time and advice to all who seek it.

**Dr Antonio Di Dio**

Dr Antonio Di Dio, the AMA ACT President, is an AMA Federal Councillor and a member of the Ethics and Medico-Legal Committee, and has served his colleagues through leadership of, and involvement with, the AMA, AMA ACT and the NSW and ACT Doctors' Health Advisory Service (DHAS), providing much-needed support to troubled doctors and their families.

In 2019, Dr Di Dio was appointed as the AMA representative to the Independent Health Assessment Panel (IHAP) and subsequently served as its Chair. His IHAP duties have required Dr Di Dio to undertake serious statutory obligations involving the exercise of his skills as a medical practitioner that have made an extraordinary call on his personal time, in circumstances that were highly politically charged.

It is a tribute to Dr Di Dio's skill and compassion that he was able to so effectively discharge his duties; a matter that reflects great credit on both him and the AMA.

**Dr Kean-Seng Lim**

Dr Kean-Seng Lim, the immediate Past President of AMA NSW and Deputy Chair of the AMA Council of General Practice, is a specialist GP with particular interests in sports medicine, nutrition and lifestyle, and integrated care. His practice in Sydney's western suburbs is built on a multidisciplinary approach, integrating doctors, nurses, allied health practitioners, and a non-dispensing pharmacist, using the Patient Centred Medical Home principles.

Dr Lim used his AMA NSW presidency to focus on measures to reduce overweight and obesity, and helped develop the schools-based obesity prevention and lifestyle education program – SALSA.

Dr Lim has passionately campaigned for increased primary care funding, arguing that early intervention and better management of long-term health problems is a more sustainable healthcare strategy.

**Dr Helen McArdle**

Dr Helen McArdle, the first female President of AMA Tasmania, is a long-standing AMA member, a highly respected AMA Federal Councillor, a senior medical administrator, and Occupational Physician and medical leader.

Dr McArdle has contributed to the work of the AMA at all levels of the organisation since 1990. A Federal Councillor since 2012, she has made landmark contributions as a member of the AMA Ethics and Medico Legal Committee, including the development of the AMA *Position Statement on Euthanasia and Physician Assisted Suicide 2016*, and as inaugural Chair of the AMA Equity, Inclusion and Diversity Committee.

Dr McArdle contributes at the highest level to her profession as a clinician, educator, leader, and policy maker.

**Professor Nicholas Talley AC**

Professor Talley is a world-leading neuro–gastroenterologist, educator and researcher, and is widely recognised as one of the most influential clinician-researchers in the world, with more than 1,000 papers published in peer-reviewed literature.

Prof Talley has been Editor-in-Chief of the *Medical Journal of Australia* since 2015, and was previously co-editor-in-chief of *Alimentary Pharmacology and Therapeutics* and editor of *American Journal of Gastroenterology*. He is also the author of the authoritative textbooks *Clinical Examination* and *Examination Medicine*.

In 2018, he was honoured with the Companion of the Order of Australia.

Professor Talley has contributed to AMA NSW and to Federal AMA by his contribution to excellence in medical education and the standards he has established for students, doctors in training, and doctors. As MJA editor, he has contributed to a highly valued member resource.

**Dr Anne Wilson and Dr Don Rose**

Dr Anne Wilson and Dr Don Rose have given outstanding service to the AMA for more than three decades, supporting each other in both their AMA endeavours and their marriage, raising four children while working as GPs in northern Tasmania.

They are active members of the AMA Tasmania Northern Division, State Councillor, and Tasmanian delegates to the AMA National Conference for many years.

Dr Wilson has been the Tasmanian representative on the AMA Council of General Practice for the past six years.

Dr Rose has represented the AMA on various bodies, including as the current AMA representative member of Primary Health Tasmania.

Both Dr Wilson and Dr Rose have been tireless in their efforts to ensure GPs remain at the centre of patient care in policy development and health service delivery in the public and private domains.

While each nomination was considered independently and on its merits, Dr Rose and Dr Wilson are a true partnership and one cannot be mentioned without speaking of the other.

# Priorities for progress

The AMA has demanded a commitment to adequate funding for the successful implementation of the new Closing the Gap agreement.

The National Agreement on Closing the Gap has the potential to deliver dramatic improvements in Aboriginal and Torres Strait Islander health and wellbeing but must be supported by funding to achieve targets, says the AMA.

Outgoing AMA president Dr Tony Bartone said that without needs-based funding, the targets would remain unattainable, continuing the trend in disappointing progress in meeting the Closing the Gap objectives.

For the first time, the National Agreement on Closing the Gap (the National Agreement) has been developed in genuine partnership between Australian Governments and Aboriginal and Torres Strait Islander peak organisations through a co-design process.

The National Agreement sets ambitious targets and new priority reforms that aim to change the way governments work to improve life outcomes experienced by Indigenous Australians. Under the agreement, all levels of government will be required to report on their progress towards these objectives.

In addition, the Productivity Commission will undertake a three-yearly independent report on progress against the National Agreement. This will be followed by an Indigenous-led review of progress every three years, and the Joint Council on Closing the Gap will have an ongoing role in monitoring progress.

'The AMA is cautiously optimistic that governments will hold up their end of the bargain and fully implement the actions under this new Agreement,' Dr Bartone said.

'Yet best intentions will not work without sustainable, guaranteed funding for programs and services.

The AMA supports the partnership approach to driving change where governments work with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses, recognising that success depends on joint ownership of the initiatives and outcomes. The approach builds on the strong foundations Aboriginal and Torres Strait Islander people have through their deep connection to family, community and culture.

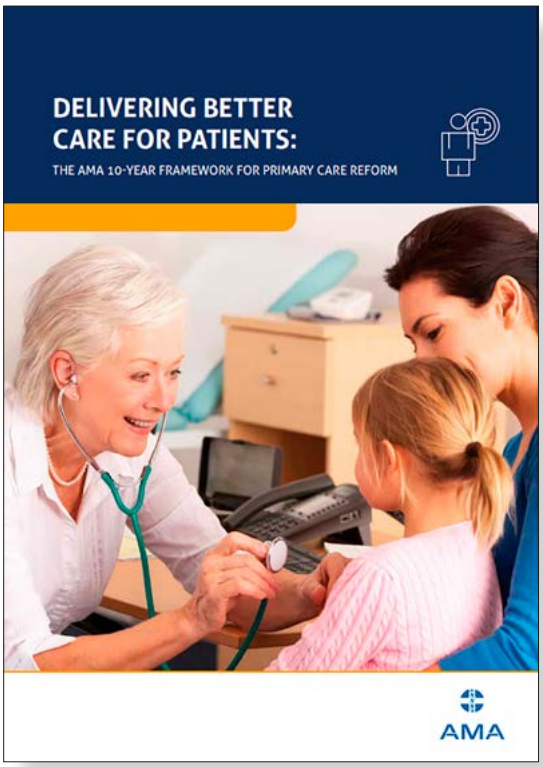
'With the targets principally developed by a network of Aboriginal and Torres Strait Islander organisations, they are set up for best possible success,' Dr Bartone said. 'We know that Aboriginal and Torres Strait Islander people have better health and life outcomes when they have a say over their lives and the policies and programs that affect them.'

**The new Agreement has the following 16 targets:**

1. **Close the Gap in life expectancy** within a generation, by 2031
2. By 2031, increase the proportion of Aboriginal and Torres Strait Islander **babies with a healthy birthweight** to 91 per cent
3. By 2025, increase the proportion of Aboriginal and Torres Strait Islander children enrolled in Year Before Fulltime Schooling (YBFS) **early childhood education** to 95 per cent
4. By 2031, increase the proportion of Aboriginal and Torres Strait Islander **children assessed as developmentally on track** in all five domains of the Australian Early Development Census (AEDC) to 55 per cent
5. By 2031, increase the proportion of Aboriginal and Torres Strait Islander people (age 20-24) **attaining year 12 or equivalent qualification** to 96 per cent
6. By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-34 years who have **completed a tertiary qualification** (Certificate III and above) to 70 per cent
7. By 2031, increase the proportion of Aboriginal and Torres Strait Islander youth (15–24 years) who are **in employment, education or training** to 67 per cent
8. By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25–64 who are **employed** to 62 per cent
9. By 2031, increase the proportion of Aboriginal and Torres Strait Islander people **living in appropriately sized (not overcrowded) housing** to 88 per cent
10. By 2031, reduce the rate of Aboriginal and Torres Strait Islander **adults held in incarceratio**n by at least 15 per cent
11. By 2031, reduce the rate of Aboriginal and Torres Strait Islander **young people (10-17 years) in detention** by at least 15 per cent
12. By 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander **children in out-of-home care** by 45 per cent
13. A significant and sustained **reduction in violence and abuse against Aboriginal and Torres Strait Islander women and children** towards zero
14. Significant and sustained **reduction in suicide** of Aboriginal and Torres Strait Islander people towards zero
15. *a)* By 2030, a 15 per cent increase in Australia's **landmass subject to Aboriginal and Torres Strait Islander people's legal rights or interests**
    *b)* By 2030, a 15 per cent increase in **areas covered by Aboriginal and Torres Strait Islander people's legal rights or interests in the sea**
16. By 2031, there is a sustained increase in number and strength of Aboriginal and Torres Strait Islander **languages being spoken.**

# Primary sources

The AMA's new vision for primary health places GPs at the front and centre of care.




Federal Government spending on general practice and primary health care should be mandated at a minimum 16 per cent of total health spending to meet the increasingly complex medical needs of an ageing community, the AMA advises.

In releasing the AMA vision for the future of primary health care and general practice, AMA outgoing president Dr Tony Bartone said COVID-19 had highlighted the chronic underfunding of general practice and the need for sustainable funding for primary health care.

'Successive governments have overseen a rate of investment in general practice that has not matched the increase in the cost of providing high-quality patient care,' Dr Bartone said.

'Government spending on GP services is about $391 per person annually, down from $395 in 2017-18.'

The vision, *Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform*, notes that while general practice is the key to ensuring a high-quality, equitable and sustainable health system, many practices have required large financial incentives to keep them viable during the pandemic.

The report notes that government indexation of Medicare rebates has not kept pace with the rising cost of medical practice. While the Consumer Price Index and medical costs increase by about 3 per cent each year, Medicare rebates increased by 1.2-2.5 per cent between 1995 and 2012, before the recent Medicare freeze prevented indexation completely.

Medicare-funded services are also often inflexible or inadequate without catering to the changing needs of patient care and red tape associated with chronic disease management and residential aged care facilities hinders primary care, the report says.

In addition, the growing prevalence of chronic health conditions has greatly increased demand for and cost of treatments, with patients with chronic diseases accounting for 47 per cent of preventable hospitalisations.

'The Australian population is growing, ageing, and developing more complex health needs as chronic disease and mental ill-health continue to increase,' the report notes. 'General practice funding models must change to meet the needs of the community.'

While telehealth has been successfully implemented and embraced during the COVID-19 pandemic to support general practice and reduce the risk of infection, it represented only a fraction of the innovation and transformation required in the rest of the general practice framework, Dr Bartone said.

The report notes that inadequate support for general practice leads to care that breaks down between general practice and other arms of the health system, and causes significant cost increases to the health system.

In 2016-17, 6 per cent of all hospitalisations were due to 22 preventable conditions that could be managed by general practice. This accounted for over 2.8 million hospital bed days.

As well as reducing pressure on hospitals, increased support for general practice and preventative primary health care is expected to have far-reaching economic and social effects, reducing absenteeism, presenteeism and poor productivity. More investment in general practice would assist in the early diagnosis and treatment of acute and chronic diseases, and improve workforce participation and economic productivity.

The AMA vision notes patient care should be integrated and well-coordinated with multidisciplinary healthcare teams led by GPs, to manage and reduce the risk of patient comorbidities and decrease the number of adverse medication events.

It outlines immediate funding goals recommended as part of the Federal Government's 10-year Primary Health Care Plan and provides a framework that can be implemented over three tranches to support the transformation of general practice into high-performing, patient-centred medical homes.

Four key recommendations sit at the centre of the vision:

- primary care reforms to build on the existing GP-led model of primary health care, which delivers high-quality, cost-effective outcomes for patients
- a suitable funding model to transform general practice into a medical home
- adequate funding for general practice to reach its full potential and meet the community's increasingly complex healthcare needs, with a mandated 16 per cent of total health spending
- continued investment in long-term strategies to ensure a sustainable medical workforce.

*Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform* is available at https://ama.com.au/article/delivering-better-care-patients-ama-10-year-framework-primary-care-reform

iStock/davidf

# Acts of kindness

The Pandemic Kindness Movement is one COVID-19 outcome that we want to continue and celebrate, writes the Commissioner on Excellence and Innovation in Health, Professor Paddy Phillips.

*Professor Paddy Phillips*

The Commission on Excellence and Innovation in Health (CEIH) works with clinicians, consumers, and other collaborators to build a health system where people are truly at the centre, where everyone has access to the latest evidence and data to make the best decisions, where innovation is encouraged and it is safe to think big and try new things, where no task is done in isolation but instead achieved through partnership and collaboration.

Given the additional pressure of the global COVID-19 pandemic, it is heartening to see partnership and collaboration come to the fore. CEIH hopes to capitalise on this spirit of openness to address a significant challenge to creating a health system where people are at the centre: the wellbeing of our workforce.

**The focus on wellbeing**

Recent surveys show that one in five doctors in training reported suicidal ideation in the past year, while half of the total number of junior doctors experience moderate or high levels of distress.

This is not unique to those in the medical professions, with nurses regularly experiencing burn-out symptoms such as depersonalisation and emotional exhaustion.

Nor is this unique to South Australia. Studies from the UK, US and globally demonstrate that poor clinician and other health-worker wellbeing leads to sub-optimal clinical care, patient dissatisfaction, staff absenteeism and turnover, and reduced team efficiency.

There are several factors that align to bring the health and wellbeing of clinicians and other health-workers to the fore, now more than ever:

- the SA Government response to the Independent Commissioner Against Corruption's report, Troubling Ambiguity: Governance in SA Health, requires each Local Health Network to develop a mentally healthy workplace plan
- the annual cost to SA Health of psychological injuries caused by the workplace is $7 million and rising
- the AMA(SA) Culture and Bullying Summit in February 2020 highlighted the impact of bullying behaviours on staff wellbeing and patient outcomes
- the Federal Health Minister's commitment to the target of zero health-worker deaths from COVID-19.

**Physician, heal thyself**

Traditionally, wellbeing is seen as an individual problem, with the individual responsible for addressing their issues. This ignores the fact that doctors struggle to identify and address their own health and wellbeing issues, with less than 40 per cent of doctors having general practitioners (GPs). Many doctors are understandably reluctant to seek help due to stigma and perceived impacts on patients, colleagues, and their careers.

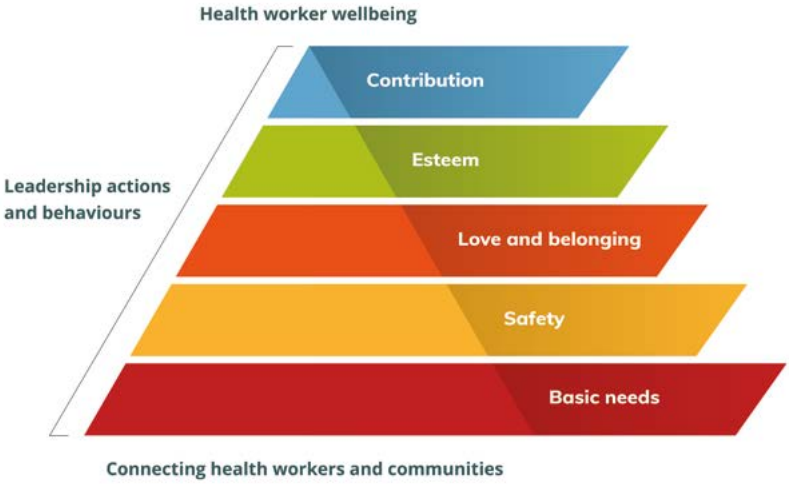
Many health systems have begun promoting strategies such as mindfulness meditation to improve wellbeing for individuals working within them, and there is evidence to support the efficacy of these approaches. However, while there are individual factors that may predispose some doctors and other health-workers to health and wellbeing issues, many of the factors that affect their wellbeing are systemic and environmental rather than inherent within individuals. These include:

- long hours without adequate recovery time
- unpredictable schedules and lack of control over work-life balance
- increasing clinical workload
- professional or geographic isolation
- cultures of traditionally being required to tolerate stress and so continuing to work despite such stress
- the complexity of navigating the health system.

**Learning from others**

CEIH's approach to improving the health system is to look for new perspectives and solutions to challenges. In relation to the health and wellbeing of South Australia's health workforce, we believe it is worthwhile to find examples of other sectors with experience of improving workforce wellbeing and learning how they succeeded. One such example is the Australian mining sector.

The mining sector employs almost 150,000 people and shares many characteristics with healthcare: a challenging work environment,



long hours, a culture that stigmatises help-seeking and barriers to accessing support services. These factors have created a workforce in which the prevalence of high or very high psychological distress is almost three times that of the general population,[1] and the prevalence of substance misuse disorders is second highest of any industry[2].

The Minerals Council of Australia launched its *Mental Health Blueprint* in 2015[3]. Key to this framework is the demonstrated commitment of leaders in the Australian minerals industry to the safety and health of its workforce, such that everyone goes to work and returns home safely, and that no task is so important it cannot be done safely.

By working with staff, unions and charities such as MATES in Construction, Energy, and Mining, mine sites have been able to raise workforce awareness of wellbeing issues and equip people with the knowledge and skills to spot when someone may require support and intervene.

MATES delivers training to workers that ranges from general awareness and crisis intervention to suicide intervention skills. Additionally, MATES accredits sites that meet the standards for mental health, safety, and wellbeing of the people that work there. The MATES program demonstrated an 8 per cent reduction in suicide, or 15 lives saved over five years in Queensland, during a period in which suicide in the general population increased.

It is interesting to note that some mining organisations have worker wellbeing a key performance indicator, so that it affects leaders' remuneration packages. This is clear evidence of leadership commitment!

**A kind response**

Doctors Health SA has for some time offered clinical services, advice and support, and co-ordinates a state-wide network of GPs with additional training in treating doctors and medical students But the pandemic has brought new, additional and extraordinary changes to our lives. Feelings of concern and anxiety are normal and expected responses as we navigate this new and uncertain situation. The Pandemic Kindness Movement was created by clinicians across Australia to support and enhance the health and wellbeing of all health-workers during the pandemic. Supported by CEIH, the Agency for Clinical Innovation in NSW, Safer Care Victoria, and the Queensland Government, it has produced respected, evidence-based resources that are curated by teams of clinicians and wellbeing experts.

The Pandemic Kindness website has resources organised under the domains of Maslow's hierarchy of needs to reflect potential challenges on the health workforce, plus leadership actions.

In the initial stages of the COVID-19 pandemic, resources in 'basic needs' (such as those addressing fatigue, sleep, nutrition and hydration) were the most accessed consistently across Australia. However, since July there has been variation between states, with South Australians prioritising resources in the 'safety' and 'love and belonging' domains.

In June 2020, CEIH worked with social change consultant Mary Freer to deliver Compassion Labs to about 80 health-workers from all professions, including doctors. The Compassion Labs teach about the physiological and psychological benefits of compassion and help participants learn how to exercise compassion in their personal and professional lives. It starts by assisting participants to be compassionate towards themselves, so they can sustain compassion towards others. CEIH is co-ordinating a compassion collaborative to continue supporting participants to build on their learning, starting in July 2020.

**Improving health-worker wellbeing**

To address the causes of poor health-worker wellbeing, several organisations, including the Office of the Commissioner for Public Sector Employment, Heads Up, and Beyond Blue, identify four domains that require action to address workplace wellbeing issues: raising awareness, preventing harm, responding to mental illness, and creating a work environment that supports mental health. These domains include individual risk factors while acknowledging the effects of the environment and system in which individuals work.

**Health-worker wellbeing program**

The CEIH health-worker wellbeing program brought together clinical, operational, and workforce leaders across the health system in South Australia on 17 August to improve health-worker wellbeing. The aim of the initial workshop was to support providers to:

- create the impetus for change
- demonstrate leadership commitment to improve health-worker wellbeing
- connect leaders with validated tools

iStock/FatCamera

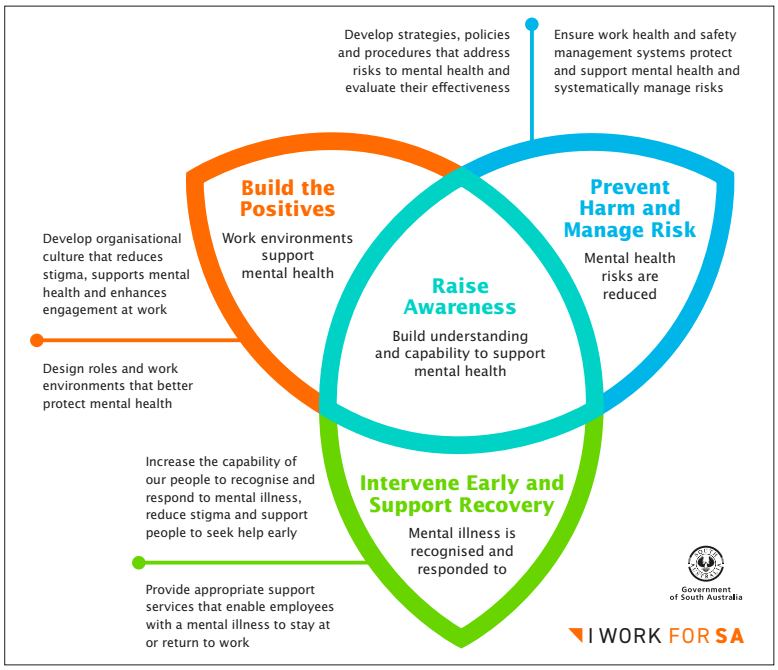
- identify practical steps that health-care providers can take to improve health-worker wellbeing
- create a network to drive systematic and environmental change.

CEIH is well placed to connect and support providers no matter where they are at on their health-worker wellbeing journey. Working at arm's length to government, we can support both public and private healthcare providers. Acting as a connector and providing constructive critique, CEIH can help identify opportunities to collaborate and learn from others in the sector, sharing best practice and helping organisations overcome specific challenges as they make changes to the environment and systems of work.

The health system in South Australia is dealing with multiple challenges. CEIH believes that a focus on health-worker wellbeing will support providers to improve healthcare for South Australians, reduce avoidable harm to consumers and workers, and make sure that everyone who comes to work in healthcare goes home safely at the end of the day.

To involve your practice, please contact mike.palmer@sa.gov.au. To access resources for support, please visit the Pandemic Kindness Movement site. If you are at immediate risk, call 000.

*Professor Paddy Phillips was appointed to lead South Australia's new Commission on Excellence and Innovation in Health in May 2019.*




***References***


1 https://www.mja.com.au/system/files/issues/208_09/10.5694mja17.00950.pdf

2 https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf?sfvrsn=90e47a4d_6

3 https://minerals.org.au/sites/default/files/MCA_Mental_Health_Blueprint.pdf

# Common decency

The pandemic has highlighted how good people respond to great challenges, writes Port Lincoln GP Dr John Williams.

*Dr John Williams*

I am motivated to write by great optimism. I'm incredibly optimistic at present because of two observations: the remarkable speed of change in health in response to the COVID-19 crisis and the corresponding 'flattening of the curve' that has given Australia the luxury of preparation and planning.

Our government has taken expert advice and the general population has taken this to heart with remarkable results – the result being that the vulnerable of our society have been protected so far.

Doctor Rieux in the Albert Camus novel *The Plague* remarked, '… the only means of righting a plague is – common decency'. He explained further that '… in my case I know that it consists in doing my job'.

In the midst of this pandemic, I thus come to the very heartening conclusion that we live in a very decent society. And that I am a member of a very decent profession.

I wrote this in April and still feel the same in August. We are having outbreaks in Australia and this was to be expected. These are being managed well but not without difficulty – which again is to be expected.

**From a rural perspective.**

We are struggling with all the changes as everywhere else in the health system. The sometimes daily changes to procedures and recommendations. The confusion created by this. The uncertainties we have and those of our patients.

We greatly appreciate the steady hand and clear thinking that is going on in medical leadership.

Rural doctors live on the fragile edge of our state's health system and have daily challenges in such logistics as patient transport, arranging basic pathology and radiology, transporting the visiting specialists to and from our communities, local management of PPE, COVID testing, etc. Almost every aspect of our daily practice has been impacted by the COVID containment measures. Our workforce is fragile. Ten per cent of our state's medical workforce is providing care to 25 per cent of the state's community.

We are extremely grateful for our metro colleagues who provide support and understanding in the care of our patients. We have a firm hope that in the future we can strengthen these strong collegial bonds and improve the outcome for our patients. And help maintain and build our rural medical workforce.

It is difficult to express how helpful it is to have a friendly voice on the other end of the line when plan A is failing and plan B is an ICU or HDU 800 km away.

# Remembering Dr Harry Nespolon

General practice members and colleagues from across South Australia have joined AMA(SA) President Dr Chris Moy in paying respects to former RACGP President Dr Harry Nespolon, who has died from pancreatic cancer.

Dr Nespolon was a graduate from Flinders and spent the early years of his career in South Australia.

Dr Moy said Dr Nespolon had been an extremely vocal and active advocate for GPs and the medical profession for many years.

'General practitioners, healthcare workers and patients across this country have benefited from Harry's dedication and his determination to have doctors' voices and concerns heard and heeded,' Dr Moy said.

'His commitment to doctors and patients continued even as his health deteriorated as Australians confronted the many challenges posed by the pandemic.

'On behalf of the AMA in South Australia, I offer condolences to Harry's family, colleagues, friends and patients.'

*Dr Harry Nespolon*

*A patient receiving treatment for a longstanding metabolic condition with trials coordinator Leanne Price*

# A testing time

South Australia's research capabilities and geographical location make it the perfect place to build a world-renowned trials industry, writes Professor Guy Ludbrook.

There has been a great deal of media focus in recent weeks on the trial of a potential COVID vaccine being developed in South Australia. We are pleased that state institutions including Flinders University, the Royal Adelaide Hospital, the University of Adelaide and SA Pathology have been able to quickly pull together substantial and valuable expertise, facilities and services to support industry to make this trial possible.

This Phase 1, first-in-human trial involves administration of the potential vaccine and placebo to 40 healthy volunteers to determine both if there are adverse effects and if it can generate an antibody response that may protect against COVID infection. As I write this on 3 August 2020, there are promising data on safety. When the final results are available, we will know more about if, and how, this product should be progressed. While we await these data, it is an excellent time to examine where the clinical trials industry is, and should be, heading in South Australia.

Scientifically based clinical trials are essential to determine whether potential therapeutic goods are sufficiently safe and effective to be registered with the relevant regulatory agency, the Therapeutic Goods Administration (TGA) in this country. These clinical trials are usually industry sponsored, and run to very high and closely monitored standards. Products must progress through a number of development phases: Phase 1 trials with small numbers, aimed primarily at safety and dose ranging; then Phase 2 and 3 trials with larger numbers and aimed at both safety and efficacy; and Phase 4 trials where high-volume use in the marketplace allows examination for uncommon risks and benefits. It is often under-appreciated that all new products in clinical practice are, in effect, still in the trials phase, and closely monitored for safety and efficacy. Hence, we should not be surprised or overly concerned if products are occasionally recalled. This is not usually a failure of development and regulation, but an example of the effectiveness of our monitoring of quality and safety.

Why should we want clinical trials in South Australia? They can be perceived as not a core aspect of healthcare; as a discretionary or even distracting activity. But nothing could be further from the truth. Firstly, it is well described that centres undertaking trials provide better healthcare. We can debate whether this relates to attracting leading

*PARC Clinical Research's senior trials coordinator Louise de Prinse in the unit*

clinicians, or exposure to the rigor and consistency in care, or clinicians and administrators seeing the benefits of continuous innovation and change, or patient improvement from innovative treatments. What we cannot debate is that these are all positive elements.

Secondly, clinical trials form a very large industry in this country, with an annual value of tens of billions of dollars. Growth in this activity is a great opportunity for the state at a time of economic challenge. Lastly, and so importantly, the trials enable our patients to receive innovative treatments that would otherwise not be available to them, without adding to the health budget.

Can we attract and expand clinical trials activity in South Australia? Absolutely – in fact, there are few places better placed to do so. We provide high-quality healthcare with excellent and connected clinicians. We have outstanding scientists and researchers, as well as highly regarded contract research organisations (CROs) and internationally recognised dedicated trials units. We have world-class infrastructure – one only needs to look down North Terrace to see an astonishing biomedical precinct.

Importantly, too, we have a state-wide electronic medical record to facilitate accurate, timely and efficient data collection. And (again as I write this), due to our state's public health policy and actions, as well as our geography, we are largely COVID-free, providing opportunities for volunteer- and patient-based trials to proceed without a major risk of interruption. All this sits on a background of Australia's substantial tax benefits for industry that undertakes clinical trials, and rapid processes for trials approval and commencement.

What do we need to do? Clinical research needs to be a high priority at a time when opportunities for South Australia are substantial, with a surge in interest in placing trials in this state. Critically, it needs to be a high priority for SA Health and its hospitals, as well as the private healthcare sector, to enhance quality of care for the reasons outlined previously. It needs rapid and visible commitment to space and infrastructure, to clinical positions with dedicated time for research and innovation, and a business model to provide the agility needed for a fast-moving industry.

This COVID trial has shown us what can be achieved in a short space of time and shone a light on the tremendous capacity and potential within this state. We must use this opportunity.

*"I'd like to acknowledge the main investigators in the COVID-19 vaccine trial, Professor David Gordon and Dr Pravin Hissaria, Vaxine Pty Ltd; the support from CALHN HREC and Research Services, RAH Pharmacy, SA Pathology, and the Department of Anaesthesia at RAH; and the incredible work of Kathy Heyman and her team at PARC."*

*Professor Guy Ludbrook is an anaesthetist, a co-investigator in the COVID-19 vaccine trial, director of an RAH-based early phase clinical trials unit (PARC Clinical Research), and provides expert advice to TGA committees.*

# Commissioner paves the way for rural and remote doctors

South Australian doctor and educator Professor Paul Worley was Australia's inaugural National Rural Health Commissioner. His sights are now on other challenges.

*Professor Paul Worley*

The shortage of doctors in rural and remote areas is the stuff of legends but not for much longer says the immediate past National Rural Health Commissioner, Professor Paul Worley.

With a new National Rural Health Generalist pathway on track for delivery – with the full support of students and the general practice and specialist colleges – as his three-year tenure ended in June 2020, he's certain the health sector is about to be transformed.

'We have proposed a 12-year pathway overall – which involves having end-to-end medical school training in the bush and then end-to-end postgraduate training in the bush – not that you are conscripted to stay there but just that the training is so good and so appropriate that you won't want to leave,' Professor Worley says.

'The first tranche of the $62.2 million announced in the 2019 Federal budget has been released and there are signs of those funds flowing. As we speak, rural generalist coordinating units are being established in each of the jurisdictions around the country.

'It is a transformative change in medical training, and it is one where Australia really will lead the world. It's also one of the reasons the government introduced legislation in the parliament to extend the role of the National Rural Health Commissioner and they have appointed a new commissioner – Associate Professor Ruth Stewart from Thursday Island.

'One of her major roles is to oversee the implementation of the pathway and continue the work on the quality, distribution and access to allied health services in rural and regional Australia.'

While a needs-based assessment will determine how many positions are created, it's likely that between 350-400 positions will be initially created, aiming to reverse decades of medical exodus from rural Australia.

'With an appropriate training program, we are confident it will be seen as a very attractive specialised field within general practice and both colleges are very excited about the prospects for the National Rural Generalist Pathway,' Professor Worley says.

With two years of the rural generalist training program allocated to acquiring additional skills, junior doctors will be trained in specialist areas such as obstetrics, anaesthetics, mental health, aged care or palliative care, based on what their community needs.

Registrars will be employed by a single employer throughout their training, ensuring they retain access to entitlements such as maternity and long service leave that they currently lose through the transition from hospitals to training in private practice.

'Increasingly, rural generalist practice is seen as having significant status as a highly skilled specialised field within general practice and it is also seen as a career meeting the needs of disadvantaged communities. For those people who want intellectual challenge, skills challenges and the challenge of meeting the needs of disadvantaged communities, rural generalist practice is just for you.

'The key to the pathway is to use what have historically been social disadvantages of rural and remote practice and flip them to become advantages. Historically, medical schools have been based in our capital cities and have had an outreach to rural Australia and those students, when they go out there, do enjoy it.'

Then, he says, many make comments such as, 'it would be wonderful to be a rural or remote doctor *but* …', with the but almost invariably related to family, social, recreation, other aspirations they have, their partner's job, the needs of their kids or their ability to see themselves working in relative isolation.

'However,' Professor Worley asks, 'if you have a medical school and a postgraduate program based in those rural and remote areas from the outset, wouldn't it be great to get to a situation where you had to convince people to go to the city, rather than convincing them to go to the bush?'

Professor Worley is confident the approach will work, having implemented the Northern Territory

Medical Program as Dean of the Flinders University medical school, and confounding the sceptics in doing so.

'We were told at that time that the workforce wasn't stable enough, that the supervisors weren't there, that students would struggle with their experiences. The exact opposite has been the case. The students have had wonderful learning opportunities and the presence of the medical school has added stability to the workforce. It has added to the attractiveness of that location for doctors and doctors are staying.

'I would anticipate that this would be the case with this pathway as it is implemented across the country. It will reinforce, stabilise and improve the status of the workforce,' he says.

Having delivered on the commitment to rural health training, Professor Worley is turning his sights to an even more intractable challenge than the rural health service shortage: the remote area medical workforce.

'Regional centres will benefit from that tree change and sea change that is occurring in Australia but remote Australia needs targeted and significant investment to have an equitable share of the education and health infrastructure that Australians otherwise take for granted. Remote Australia currently relies on a fragile workforce supply chain which leaves it vulnerable at the best of times, and even more so with threats like COVID-19.'

Having seen the potential of the rural generalist pathway, Professor Worley is excited about the prospects for applying it to health care in remote areas.

'It was a great privilege to travel the country to meet rural doctors and other rural health professionals all across our wide brown land and to hear their stories of challenge and success and bring them together in a way that creates hope for a better future,' he says.

'Watch this space – there's a lot more work to do and I've got even more enthusiasm to be part of it having seen what we've been able to achieve in the past couple of years. The time is right to really push ahead and change the paradigm forever.'

# Rural advocate takes the reins

Rural health advocate, medical practitioner and researcher Associate Professor Ruth Stewart has been appointed as Australia's second National Rural Health Commissioner.

The Government recently extended and expanded the Office of the National Rural Health Commissioner to have a broader focus. The Commissioner will be supported by two Deputy Commissioners to look after allied health, nursing and Indigenous health.

Minister for Health Greg Hunt said the Federal Government is delighted to appoint Associate Professor Stewart to this important role.

'One of the early priorities for the expanded Office will be to support the Government's ongoing rural response to COVID-19 and to examine the impact on health workforce planning in regional, rural and remote communities,' Minister Hunt said.

'Associate Professor Stewart's wealth of experience and expertise will be invaluable in driving the Australian Government's commitment to improving rural health outcomes around the nation.'

A/Prof Stewart has had a distinguished career in rural health, both as a practitioner and an academic, most recently working as an Associate Professor of Rural Medicine, Director of Rural Clinical Training and Support at James Cook University. She lives and works on Thursday Island, where she has been a Senior Medical Officer with obstetric credentialing.

A/Prof Ruth Stewart said it will be a great privilege to work with rural and remote communities to improve their health outcomes, helping set priorities and develop strategies to best serve rural and remote Australia.

'I will work with Aboriginal and Torres Strait Islanders peoples across the nation to ensure that these policies are culturally safe and directed at closing the gap,' she said. 'This is an exciting challenge for my office to develop and promote innovative and integrated approaches to health care delivery in rural and remote areas.

'Working with the Deputy Commissioners I will be able to focus on the whole of the multidisciplinary team.

'In this I am fortunate to be able to pick up the National Rural Generalist program of work for medicine and allied health conducted by my esteemed predecessor, Professor Paul Worley the inaugural Rural Health Commissioner.'

# AMA promotes rural pathways

In May 2020, the AMA released a new position statement to promote rural specialist training pathways.

The AMA position is that to achieve this, the current barriers for accreditation of prevocational and vocational training posts in rural and regional areas must be identified and addressed.

The ideal outcome is increased training of doctors with skills specific to the unique requirements of remote and rural areas and increased retention of non-GP specialists outside of metropolitan centres.

The AMA acknowledges that some colleges have formulated their own strategies for developing and implementing rural training pathways. However, there are still significant barriers for many more trainees.

Key principles of the position statement are:

- ensuring quality and safety
- moving to competency-based training rather than time-based training
- developing clinical mentoring networks
- introducing flexible assessment
- utilising technology to guarantee adequate supervision
- funding positions appropriately
- using data effectively.

The Rural Training Pathways for Specialists Position Statement 2020 is available on the AMA website.

# Eating for the planet

An Adelaide contributor to an international study of dietary guidelines says Australia should overhaul its guidelines to meet its health and environmental objectives.

*University of Adelaide researcher Luke Spajic*

A University of Adelaide researcher is part of an international team that has found most national dietary guidelines do not meet global environmental and health targets.

Adelaide Medical School Honours student Luke Spajic has worked with lead author Dr Marco Springmann of Oxford University since the beginning of 2019. Mr Spajic was a visiting research student with the Centre on Population Approaches for Non-Communicable Disease Prevention at Oxford, when COVID-19 led to his early return to Adelaide in March.

The team's paper, published last month in *The BMJ*, examined the health and environmental impacts of 85 countries' dietary guidelines. It was the first of its kind to analyse both the health and environmental outcomes of national food-based dietary guidelines (FBDG) around the world.

Mr Spajic says there are environmental consequences to FBDG adoption, whether or not environmental sustainability is explicitly mentioned in a country's guidelines document.

'Poor diet and associated diet-related chronic diseases are responsible for 14.7 per cent of all Australian deaths and 75 per cent of the Indigenous health gap,' Mr Spajic says. 'Dietary guidelines are the basis for advice given by doctors and dieticians and the basis of nutrition policy. Our analysis found that the Australian diet is the most emissions-intensive among the G20, 50 per cent higher than that of Argentina, whose diet comes in second.

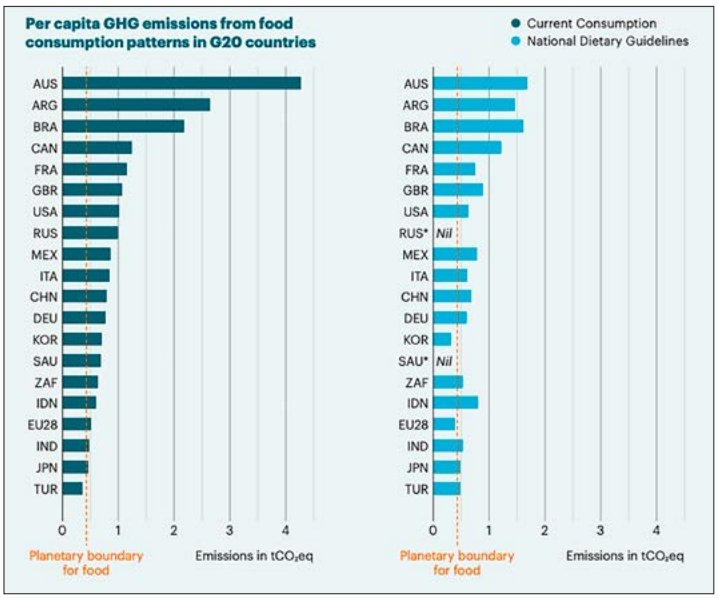
'Australia's current dietary guidelines would exceed the climate budget by a factor of 4.3 if adopted.'

Mr Spajic says despite researchers' calls for environmental sustainability to be included in dietary guidelines since the 1990s, most FBDGs do not explicitly mention environmental sustainability. Then, in late 2019, the World Health Organization published guiding principles on healthy and sustainable diets in recognition of the importance of including environmental sustainability.

'There was a joint campaign from researchers and civil society organisations, such as the Public Health Association of Australia, to include environmental sustainability in Australia's most recent dietary guidelines, but this was successfully opposed by industry,' he says.

For this study, Mr Spajic and his colleagues modelled the adoption of guidelines at both the national and global level, and compared the impacts to global diet-related environmental and health targets that governments have agreed to. These included the goal to reduce premature mortality from non-communicable diseases by a third, and the agreement to limit global warming to below 2 degrees Celsius.

On average, adoption of national dietary guidelines was associated with




| | Macronutrient intake grams per day (possible range) | Caloric intake kcal per day |
|---|---|---|
| Whole grains | | |
| Rice, wheat, corn and other | 232 | 811 |
| Tubers or starchy vegetables | | |
| Potatoes and cassava | 50 (0–100) | 39 |
| Vegetables | | |
| All vegetables | 300 (200–600) | 78 |
| Fruits | | |
| All fruits | 200 (100–300) | 126 |
| Dairy foods | | |
| Whole milk or equivalents | 250 (0–500) | 153 |
| Protein sources | | |
| Beef, lamb and pork | 14 (0–28) | 30 |
| Chicken and other poultry | 29 (0–58) | 62 |
| Eggs | 13 (0–25) | 19 |
| Fish | 28 (0–100) | 40 |
| Legumes | 75 (0–100) | 284 |
| Nuts | 50 (0–75) | 291 |
| Added fats | | |
| Unsaturated oils | 40 (20–80) | 354 |
| Saturated oils | 11.8 (0–11.8) | 96 |
| Added sugars | | |
| All sugars | 31 (0–31) | 120 |

*G20 countries' per capita dietary greenhouse gas emissions in relation to 'carbon budget' for food (left) and (right) EAT-Lancet Commission's recommended 'planetary health diet'*

a 15 per cent reduction in premature mortality, and a 13 per cent reduction in greenhouse gas emissions from the food system. However, one-third of the guidelines were incompatible with the global health agenda on non-communicable diseases, and between 67 per cent and 87 per cent were incompatible with the Paris Climate Agreement and other environmental targets.

Together, 98 per cent of national guidelines were incompatible with at least one global health and environmental target, meaning that even if the whole world followed them, the global population would still fail to meet the targets governments have signed up to.

The study also assessed the global dietary recommendations from the World Health Organization (WHO) and the more comprehensive and ambitious recommendations of the EAT-Lancet Commission on Healthy Diets from Sustainable Food Systems. It found that if populations followed the WHO recommendations it would likely result in health and environmental outcomes similar to those from following current national guidelines.

However, adoption of the EAT-Lancet recommendations was associated with a one-third greater reduction in premature mortality, more than three times greater reductions in greenhouse gas emissions, and general attainment of the global health and environmental targets.

In Australia, the study found, adopting the EAT-Lancet recommendations could lead to 86 per cent less food-related greenhouse gas emissions and 31,000 fewer diet-related deaths, compared to 46 per cent and 28,000 if current guidelines were adhered to.

'As the AMA emphasised when declaring a climate emergency, it is not possible to separate human and planetary health, regardless of whether the environment is explicitly referenced,' Mr Spajic says. 'Fortunately, there is great overlap between the latest evidence on healthy eating and what constitutes an environmentally sustainable diet.

'The flexitarian EAT-Lancet diet was formulated with the exclusive goal of identifying the healthiest diet, and only afterwards assessed for its environmental impacts. The EAT-Lancet diet and the changes we recommended to FBDGs, including Australia's, are consistent with the Mediterranean diet – more whole grains, more nuts and seeds, more legumes and less red meat (particularly processed red meat) – would make the guidelines healthier and tremendously more environmentally sustainable.'

Mr Spajic says the Australian Government announced that it would review Australia's dietary guidelines the day after the paper was published.

'This is the perfect opportunity for health professionals and the AMA to advocate to ensure our next guidelines reflect the best available evidence on healthy and sustainable diets,' he says.

'Keeping industry out of this process, as was done in Canada, is essential to ensure the public of the integrity of the guidelines.

'The best dietary guidelines are meaningless if not backed by policy – and in this country, the largest global risk factor for disease is not a government priority. At the moment, Australia's FBDGs are incompatible with climate targets the Australian government has agreed to and the Australian public expects us to meet.'

Mr Spajic says general practitioners and medical education have important roles in encouraging healthy eating practices.

'GPs collectively see most of Australia's population each year,' he says. 'This presents a perfect opportunity to highlight to Australian adults and children the benefits of healthy diets. But it's not just GPs who should be promoting good nutrition - the health benefits are relevant to all specialties.

'The focus should start in medical school. A review published in the Lancet Planetary Health in 2019 found that medical students are not supported to provide high-quality, effective nutrition care, something I witnessed first-hand in medical school. It recommended that medical education – and the effectiveness of future doctors – could be improved by making nutrition education compulsory in medical training.'

He says health promotion campaigns are also essential – including in countering the lobbying, public campaigns and funding of studies that create doubt about the links between particular food groups and disease or environmental degradation, as has been seen with a sugar-sweetened beverage tax. But, he says, they must be backed with a range of other policies to be effective.

'Some may refer to such policy as the "nanny state", but it is clear from the evidence that a hands-off approach has failed,' he says. ' Two-thirds of Australians are overweight or obese, with rates still rising, and only 5 per cent consume the recommended vegetable intake.

'And as previously stated by VicHealth CEO medical doctor Sandro Demaio, if two-thirds of a teacher's class were failing, we would surely question the teacher rather than solely the willpower of the pupils.'

The research paper is available at: https://www.bmj.com/content/370/bmj.m2322

## We are what we (don't) eat

### The researchers recommended:

- Changing national and WHO dietary guidelines in line with the current scientific understanding on healthy and sustainable diets, and providing concrete examples in terms of different dietary traditions and patterns, including predominantly plant-based ones such as pescatarian, which, when well composed, were found to be among the healthiest and most sustainable.
- Improving the environmental sustainability of dietary guidelines by providing stringent guidelines on the recommended consumption of animal-source foods, in particular beef and dairy, in regions such as Australia where they are consumed in large quantities.
- In most regions, providing clear advice on increasing the intake of whole grains, fruits, vegetables, nuts, and legumes; reducing the intake of red and processed meat; and highlighting the importance of maintaining a healthy weight.
- Addressing the currently poor adherence to dietary guidelines by investing in measures that would help populations improve their diets, such as health promotion programs, aligning menus in school and work-place canteens, and ensuring that healthy food is the easiest, cheapest choice.

Supported by:
AMA
South Australia

AMA INSURANCE BROKERS

# YOUR PERSONAL CLAIMS ADVOCATE

We can help get you the best outcomes
**because we work for you and not the insurers.**

When you have an unforeseen event, you can leave the insurance claim to the experts.

## 3 ways we can help you during a claim

**Expert advice**

### Expert Advice

Our advice doesn't stop once we've arranged your insurance policy.

We can give you advice throughout the claims process and can advocate on your behalf with insurance companies for no extra charge.

**Faster claims**

### Faster Claims

With AMA Insurance, you've got an expert you can trust on your team, who can manage the claims process on your behalf, allowing you to focus on what really matters.

**Better outcomes**

### Better Outcomes

As a Steadfast member, we leverage the support of our network so that you've got the added benefit of a large organisation who can help if an issue arises.

We can support you to manage your claim and champion it at the highest level with insurers.

Free call **1800 262 287** or visit **amainsurance.com.au**

**Rebecca Hayward**

AMA(SA) Member Services Manager

There's no doubt COVID-19 has brought with it many challenges and changes to the way we live and work. But for our doctors who have been at the coalface, there are the extra responsibilities of caring for others while also trying to keep themselves, their families, co-workers, and the wider community safe.

I have had the privilege of speaking with countless members from around the state as they tried to grasp, and adjust to, the ever-changing landscape of COVID-19, and the speed in which changes have occurred. From the Doctor in Training concerned about employment, to the rural GP worried about their community and accessing PPE, to the numerous specialists trying to treat patients remotely and surgeons who suddenly couldn't operate, I was reminded during every call why the AMA does what it does – and of the importance of our strong, trusted advocacy and respected leadership amid the storm. We are the 'go to' for evidence-based policy and advice, and in many cases for a calm and reasoned voice of comfort.

However, the strength of our voice and influence and our capacity to make a difference rely on our status as representing all South Australia's doctors.

The AMA is the only membership organisation representing all doctors and disciplines. There's never been a more important time to work together, and with a broad suite of disciplines and Adelaide and Flinders University Medical Schools represented on our Council, you can be assured that in joining the AMA in South Australia your voice is welcome and heard.

To our existing members, thank you. Your support has made it possible for us to achieve all that we have for doctors and the wider community, which recently includes:

- contributing to plans to stop the spread of COVID-19
- introducing telehealth MBS and electronic prescribing
- providing financial and mental health support for doctors
- advocating for adequate PPE
- supporting Doctors in Training and medical students.

**The battle continues. Please join us to strengthen your voice, and ours.**

To find out more, please go to https://sa.ama.com.au/membership, or contact me on 08 8361 0108 or at membership@amasa.org.au.

# AMA(SA) Member Benefits

## AMA Fees List

The AMA List of Medical Services and Fees is an important reference for medical practitioners to assist in determining fees.

Available free to members, and via subscription to non-members for $499/year.

For more details and to access the list, go to https://feeslist.ama.com.au/.

**********

## doctorportal Learning and CDP Tracker

Available free to members, doctorportal Learning offers high-quality medical education, and a streamlined way of tracking your learning and meeting your Medical Board of Australia reporting obligations.

CPD Learning (valued at $11/module) offers a broad range of educational content such as practice management, ethics and professionalism, and leadership and management.

CDP Tracker (valued at $22/month) covers multiple specialities and non-specialties and enables you to upload and track your external learning, plus have Medical Board of Australia/AHPRA audit-ready reports at your fingertips.

More information is available at www.dplearning.com.au.

**********

## Norman Waterhouse

Members receive discounted rates from our long-term partner and preferred provider of legal services, Norman Waterhouse. Its team offers a full suite of legal services across areas including employment, industrial relations, commercial and business structuring, family law, wills, and probate.

Contact Lincoln Smith on 08 8210 1203

**********

## Hood Sweeney

Members receive discounts including 10% on accounting services and 20% on the establishment of a new self-managed superannuation fund from our long-term partner and preferred provider, Hood Sweeney. Doctors in Training receive additional benefits, including your first tax return free.

Contact the Health team at amasa@hoodsweeney.com.au or call 1300 764 200 for more information.

**********

## Austofix

AMA(SA)'s recent partnership with leading Adelaide-based medical device manufacturer Austofix gives members access to high-quality PPE (branded Austosafe) when you need it most, and from a company that guarantees our members will receive fast, customised service.

More information is available at https://austosafe.com.au/.

**********

## Mercedes-Benz Adelaide

Save thousands and enjoy a range of benefits with Mercedes-Benz Corporate Program, including three years' complimentary scheduled servicing, reduced retailer delivery fee and complimentary loan car, or pick-up/drop-off when servicing your vehicle.

For more details contact paul.griffin@mbadelaide.com.au or call 08 8152 5000.

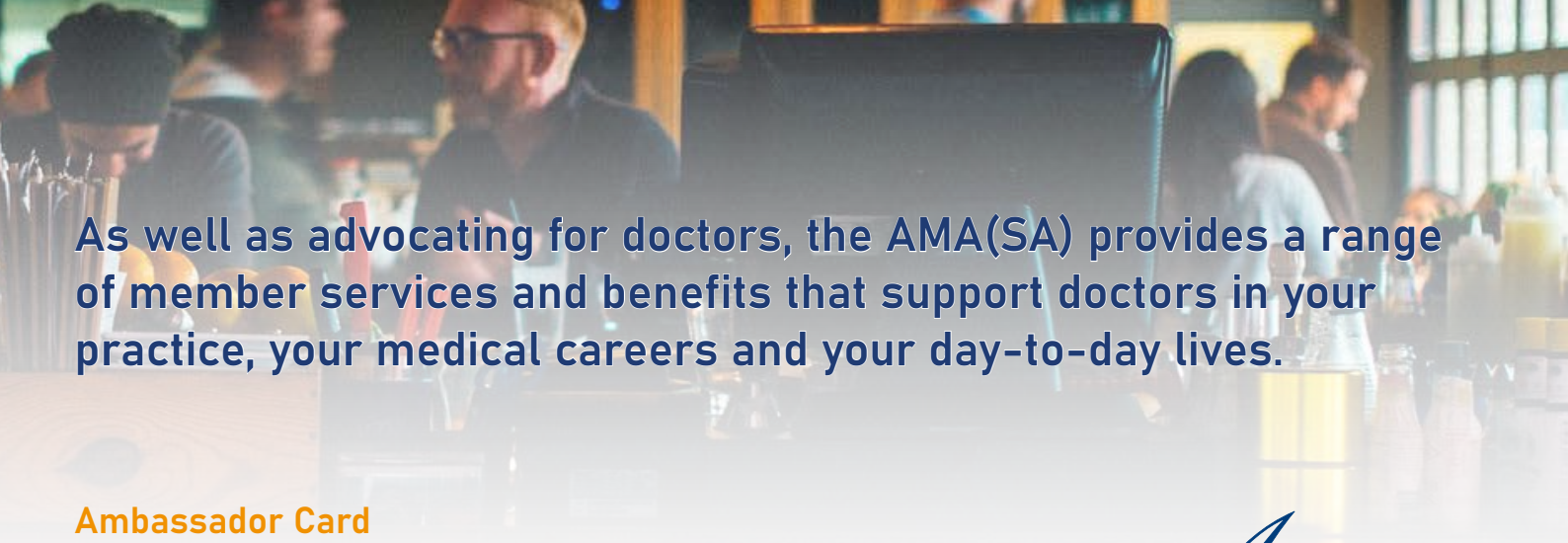
**********

## American Express

Members receive a range of benefits with the AMA American Express Platinum and Platinum Edge Cards, including a reduced annual fee and complimentary Accor Plus membership.

For information on all Federal benefits go to https://ama.com.au/membership/benefits.

**********



## As well as advocating for doctors, the AMA(SA) provides a range of member services and benefits that support doctors in your practice, your medical careers and your day-to-day lives.

### Ambassador Card

Members save at over 2,400 outlets including restaurants, cinemas, attractions and accommodation, and a huge range of retail outlets including Coles Myer, David Jones, Freedom, Witchery, Rebel Sport, Adrenaline, Barbecues Galore, Priceline Pharmacy and Sheridan.

Members can also make significant savings on a wide range of home, electrical and entertainment products at the new Online Shop.

On all benefits, including those below for details please go to ama.ambassadorcard.com.au, and log in using your SA Membership ID and email address.

#### Goodlife Health Clubs

Save 15% on your Active Plus Membership and receive a wide range of additional benefits from all Goodlife Health Clubs. To redeem, present the offer available on ama.ambassadorcard.com.au, and show your Ambassador Card.

#### Hoyts eGift Card

Save on a range of ticket and candy bar vouchers, plus 8% on e-Gift cards when purchasing online.

#### Event Cinemas eGift Card

Save on a range of tickets and food and beverage e-vouchers, including Gold Class, plus 7% on e-Gift cards when purchasing online.

#### The Home eGift Card

Save 10% when purchasing online. Redeemable at Adairs, House, Wheel & Barrow, Provincial Home Living, Matt Blatt, Matchbox, Robins Kitchen and VIP Home Services.

#### isubscribe

Save 10% on already discounted prices on over 2,000 magazines.

#### Country Road eGift Card

Save 7.5% when purchasing online. Valid at all Country Road outlets and online.

# 480 Specialist Centre

OVER 150 CONVENIENT FREE PATIENT CAR PARKS


## SPECIALIST SUITES NOW AVAILABLE

The 480 Specialist Centre located on North East Road, Windsor Gardens is now open and offers purpose built medical specialist accommodation along with a state-of-the-art Day Surgery facility. Visit our website for our specialist directory and sessional suite availability and booking form **www.480specialistcentre.com.au.**

**Qscan Radiology Opening Q1 2021**

## Australian Clinical Labs at Windsor Gardens

### COMBINING PATHOLOGY LEADERSHIP, GROUND-BREAKING TECHNOLOGY AND THE BEST SCIENTISTS IN THE FIELD.

At Clinical Labs we pride ourselves on being leaders in science and technology. Recently partnering with 480 Specialist Centre, Clinical Labs are one of the largest pathology groups in Australia, and our NATA-accredited laboratories offer local clinicians a vast array of pathology services including:

- **All routine pathology tests**
- **Histopathology**
- **Biochemistry Microbiology**
- **Toxicology**
- **Covid-19 PCR testing**
- **Molecular biology**
- **Immunology**
- **Commercial pathology**
- **Advanced pathology**
- **Haematology**
- **Serology**
- **Functional pathology**
- **Antenatal screening (FTS and Harmony® NIPT)**
- **Molecular cancer tests (Aspect Liquid Biopsy, Somatic Mutation, EndoPredict®)**

To find out more about the pathology services offered by Clinical Labs please call us on 1300 134 111 or Windsor Gardens direct on 8369 0494.

**Mon-Fri 9am – 5pm**

**clinicallabs.com.au**

For information about leasing opportunities

**ANDREW McINTYRE**

**MRS Property | M 0422 303 585**

480

SPECIALIST CENTRE

# New technologies, new hope

A quiet revolution is afoot in paediatric neurology, with new technologies bringing new treatments and new hope for children with neurological illness, writes paediatric neurologist and Australian Medical Association (SA) Councillor Dr Clair Pridmore.

*Dr Clair Pridmore*

Exciting advances in neurodiagnostics and therapeutics have revolutionised the practice of paediatric neurology in South Australia in recent years, and our paediatric neurologists are enthusiastically capitalising on these technological developments.

We frequently used to hear statements like, 'Neurologists are good at making diagnoses, but can you actually treat?'. But with recent advances, this is no longer the case. Due to the explosion in genetic techniques in particular, it is now uncommon for patients to reach adulthood without a diagnosis. Genetic diagnoses arm families with the knowledge they need about known co-morbidities, risks and prognosis, and assists with family planning for the parents and wider family. Genetic diagnosis is likely to become even more important in the future, as it provides targets for precision medicine.

Picture an infant who has just been diagnosed with spinal muscular atrophy, already very weak, but alert, with normal intelligence. Only a few years ago, we had to counsel parents that death from progressive weakness was expected within two years. Now, due to improvement in the molecular understanding of this disease, we offer a gene therapy that has been proven to allow children to achieve some motor milestones and extend life expectancy. This is a great example of bench-to-bedside medicine.

Advanced neuroimaging technologies including functional magnetic resonance imaging (MRI) and nuclear medicine imaging have transformed the surgical management of epilepsy, making seizure freedom a reality for some children. Rapid expansion in our understanding of the molecular basis of the epilepsies has allowed precision in medical management for more and more patients.

The list is long in terms of major developments in this subspecialty over the past 10 years or so. Autoimmune encephalitis was not a recognised entity until recently; now we provide targeted immune therapies, which significantly improve outcomes. At the same time, paediatric multiple sclerosis was previously under-recognised and undertreated. Advances in therapeutics have improved the clinical course for these children.

All neurologists are involved in clinical research conducted outside their SA Health commitments. Under unit head Dr Nicholas Smith, in collaboration with the University of Adelaide, Flinders University and the South Australian Health and Medical Research Institute, the team is leading the development and delivery of gene therapy technologies for childhood dementia and other neurodegenerative disorders. Excitingly, they are also developing cutting-edge methods to facilitate personalised drug screening and the development of precision therapeutic strategies for these disorders.

Our Australian Collaborative Cerebral Palsy Research Group has found that cerebral palsy, previously assumed to be exclusively due to acquired factors such as a difficult birth, frequently has a genetic contribution. Furthermore, in a collaboration with Melbourne researchers, the Adelaide team is implementing clinical guidelines for childhood stroke, to improve diagnostic and treatment timeframes, provide greater access to reperfusion therapies, and close the gap between children and adults.

Innovative technologies and therapies have been eagerly embraced by South Australia's paediatric neurologists for their patients but keeping up with the exponential growth in service demand is proving challenging. The department is hoping that additional resources can be secured to meet the accelerating demand and to position itself as a centre of excellence in the coming years.

It will also be essential to grow our capacity to train the paediatric neurologists of the future. It is a very exciting time for our specialty and it is certain that further advances will follow in quick succession, promising a brighter future for children with neurological illness.

# Experts for your financial health.



Hood Sweeney is a long term partner of the Australian Medical Association of South Australia providing accounting and financial planning services to their members.

Our Health team understands the complexities of everything from setting up a medical practice – including IT and service fees – to selling it, along with personal financial planning, wealth protection, tax strategies and performance coaching.

**For a second opinion on the fiscal fitness of your practice or your personal finances, email our Health team on amasa@hoodsweeney.com.au or call 1300 764 200.**

HOODSWEENEY
join the journey

ACCOUNTING & BUSINESS ADVISORY
CONSULTING & PERFORMANCE COACHING
FINANCIAL PLANNING
TECHNOLOGY SERVICES
FINANCE
PEOPLE & CULTURE CONSULTING
BRANDING & MARKETING ADVISORY

**T** 1300 764 200 **F** 08 8232 1968
info@hoodsweeney.com.au
www.hoodsweeney.com.au

+ Lisa Hickey and Heang Lay are Representatives of Hood Sweeney Accounting & Business Advisory AFSL 485569

* Adrian Zoppa and Mark Mullins are Representatives of Hood Sweeney Securities Pty Ltd AFSL No. 220897

# Making dreams happen

DREAMIN is an acronym for the Dean Richards Endeavour to Assist the Medically Ill and Needy. It honours the memory of the late Dean Richards, a stalwart of the Rotary Club of Prospect. It was founded in 2003 and provides a mechanism to support appropriate medical intervention services for those people in need in South Australia, Australia and developing countries. The Foundation is chaired by Professor Suren Krishnan and its board includes junior doctors, members of the Rotary Club of Prospect and the wider community.

The Annual DREAMIN Foundation Adelaide Cup Day function was held on 9 March at the beautifully renovated Dulwich House. We were so thankful we could hold our function before South Australia's COVID-19 lockdown and that due to the generosity of members and donors, the event raised about $30,000.

The foundation's work with Maranatha Health in Uganda continues to gain the attention of our supporters. The Maranatha health team announced plans to build a new hospital and remain in Fort Portal. The existing facility has about 30 beds and the plan is to build a 200-bed facility with additional paediatric, maternal health and community health services. Land has been purchased and planning is underway. A very generous philanthropic Adelaide family has since provided $50,000 towards the foundation's vision to support the development of operating room facilities for the new hospital.

The DREAMIN Foundation organises fundraising events during the year to support the vital work being carried out by generous South Australians. As a charity, the DREAMIN Foundation relies on the generosity of members of the Prospect Rotary Club, associated medical professionals, and members of the DREAMIN Foundation to raise much-needed funds to continue the valuable work of the Foundation.

For more information, including how to donate, go to dreamin.org.au

*Dr Jarrad Hopkins is a director of the DREAMIN Foundation.*

*Dr Jarrad Hopkins (left) and Professor Suren Krishnan (right), with DREAMIN volunteers at the March 2020 fundraiser at Dulwich House (below)*

# Seeking common ground

**LIAM RAMSEY**
STUDENT NEWS:
FLINDERS UNIVERSITY

Doctors are expected to be steadfast, omnipotent, iron-clad in the face of uncertainty, but also warm, considerate, and empathetic. These contrasting qualities reflect the colliding biomedical and anthropological arms of medicine. It has long been held that doctors showing vulnerability is a sign of weakness and an inherently negative quality. But this paradigm is shifting. Emerging discourse now paints vulnerability as an important tool and a real strength.

Vulnerability is defined by the *Oxford Dictionary* as 'the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally'. We cannot escape being vulnerable as doctors. In the doctor-patient relationship, it is fundamental for the establishment of trust and meaningful connection; it underpins collaboration, help seeking, and reporting medical errors. Despite this, we continue to attempt to circumnavigate this intrinsically human experience. This should be challenged. Vulnerability should instead be recognised as a clinical tool to enhance our role as doctors and as humans to help us navigate life, death, and difficult circumstances.

Vulnerability can improve doctors' ability to empathise with patients and the capacity to create innovative and personalised management plans. Qualitative research of GPs' experience of vulnerability has found that doctors who appreciated commonalities between themselves and their patients enhanced their ability to be compassionate. Further, it fostered their own internal awareness of emotions and reflexivity, similar to countertransference and psychodynamic tools already used by some doctors such as psychiatrists and GPs. Despite our society being increasingly pluralistic it is crucial we continue to find commonality with our patients.

For doctors to safely capitalise on their vulnerability they must be cognisant of their shortfalls and mistakes. It means expressing uncertainty, something that is often perceived as failure by the medical profession. We should challenge this notion and invite doctors to be human. We should rephrase intentional and meaningful vulnerability as a strength, rather than weakness. Emotional intelligence underpins much of our success in medicine and it's a skill we need. It can be unnerving for some of us as it often challenges cognitions learned during our induction to medicine. It can be unsettling and fraught with feelings of shame and not belonging.

Yet there is a flipside to the benefits for our profession and patients. Unchecked doctor vulnerability can lead to empathy burnout. Oversharing can be perceived as unprofessional by patients or impair their trust in us. Deviations from the traditionally steadfast approach may cause undue anxiety for patients already feeling significant uncertainty.

Vulnerability that is measured, purposeful, and meaningful can enhance doctor-patient, doctor-doctor, and doctor-allied health professional relationships. As I finish medical school, I have been in awe of some doctors' control of their emotional state and self-awareness of ego and self, and how they use this to optimise patient care. As I leave medical school and join the next generation of doctors, I am inviting and encouraging myself to be human. I am re-defining my vulnerability and will endeavour to find strength in openness and weakness.

# Changing tradition without dampening our spirits and bringing back the gaudium

**JADE PISANIELLO**
STUDENT NEWS:
ADELAIDE UNIVERSITY

For 135 years, the Adelaide Medical Students' Society has upheld three core values: 'traditio, spiritus, gaudium' – tradition, spirit and good times. Although 2020 has seen traditional medical school life go out the window, the AMSS has been hard at work delivering virtual good times and upholding spirits for some 900 medical students across all six years of the program.

This time of year classically marks the beginning of much-awaited holidays for students in the years 4-6, with many of the final years heading abroad for their Dean's Elective: an opportunity to pursue a month of clinical practice in any medical field, in any part of the world. For pre-clinical students in years 1-3, these colder months make the trek to the Medical School on North Terrace even harder, with their holidays just in sight. In the context of COVID, medical students across all years at the University of Adelaide were pulled from hospitals and in-person university teaching in April. Preceding the clinical placement and teaching pause, the year 6 students were told that overseas travel could understandably not go ahead.

So, the usual mark of the beginning of holidays for students in years 4 and 5 was instead met with a long-awaited and much anticipated return to clinical placements. For pre-clinical students in years 1-3, the beginning of the second semester marked the return to face-to-face teaching. Through the dedication of faculty members, the AMA(SA) and countless hospital clinicians, Adelaide University medical students were finally permitted to head back into hospitals and the medical school. Having placement and in-person teaching so abruptly halted, the ramble into hospital or university day after day suddenly seemed not so tedious. The final-year cohort, who recommenced placement back in April, have certainly enjoyed seeing the faces of our younger colleagues in corridors and theatres.

The delivery of medical education via exclusively digital means was difficult for student and teachers alike. Teaching to a screen of tiny rectangles could not have been without its challenges – and yet, the consultants we know and love brought their best e-selves forward to deliver informative and entertaining teaching.

The easing of restrictions has meant medical students can go back to what they do best: learning from South Australian doctors, nurses and patients in hospitals or our new medical school and, of course, planning the delivery of our rich social and educational events. From MedRevue to Graduation Week, practice examinations to EdForum, the AMSS is slowly but surely emerging from hibernation and bringing back the gaudium. In mid-August, the AMSS was permitted to host the first in-person event since our annual MedCamp at Normanville in March. The society presented InterYear Comedy Debating, when we saw the final year students debate the fresh-faced first years and, for the first time, the Adelaide Medical School went head to head with the Flinders Medical School debating team.

With final-year students having just been notified at which hospital networks they will complete their internships, we cannot help but look to the future and wonder when this chapter of 'unprecedented times' will draw to a close. For now, we are grateful for the few moments where we are able to safely interact with each other, whether this be in hospital, on campus - or even across the debating stage.

# Tattoo free breast radiation therapy now available at all GenesisCare treatment centres in SA

We are dedicated to providing excellent patient care and deliver radiation treatment without using permanent tattoo marks, eliminating the constant reminder of a cancer diagnosis and treatment.

**Dr Marcus Dreosti**
BSc, Hons LLB, MBBS (Hons) FRANZCR

**Dr Joshua Sappiatzer**
MBBS, FRANZCR

**Dr Caroline Connell**
BMBS (hons) FRANZCR

**Dr Phuong Tran**
MBBS, FRANZCR

**Dr Andrew Potter**
MBBS, BMedSc(Hons), FRANZCR

**Dr Laurence Kim**
MBBS, FRANZCR

**For further information please contact our team at**

St Andrews Hospital
352 South Terrace
Adelaide SA

**Tel: 08 8228 6700**
infooncologysa@genesiscare.com

genesiscare.com

GenesisCare


As a member of the Australian Medical Association SA, enjoy exclusive benefits such as complimentary 5 years/ 80,000km BMW Service Inclusive Basic package*.

When you or your spouse purchase a new BMW before 30 September 2020, receive a complimentary Samsung product of choice^:

- Samsung Galaxy S20 Ultra 5G 128GB
- Samsung 75" QLED 4K Smart TV – Q60T

Enjoy the latest technology and design on the road and at home.

**Visit your participating BMW Dealer today.**

Offer applies to new BMW vehicles ordered between 01.07.2020 and 30.09.2020 and delivered by 31.10.2020 at participating authorised BMW dealers by Australian Medical Association SA members or their spouse. Limited edition models exclusions apply. Excludes fleet, government and rental buyers. *Complimentary service inclusive - Basic, including Vehicle Check, is valid from date of first registration or whichever comes first of 5 years/ 80,000km and is based on BMW Condition Based Servicing, as appropriate. Normal wear and tear items and other exclusions apply. Servicing must be conducted by an authorised BMW dealer in Australia. ^Samsung Galaxy S20 Ultra 5G 128GB or 75" QLED 4K Smart TV – Q60T. Not redeemable for cash and is not negotiable or transferable. Unless excluded, this offer may be used in conjunction with other applicable offers during the promotion period. Subject to eligibility. Terms, conditions, exclusions and other limitations apply, and can be viewed at bmw.com.au/corporate.

# Heroes are people too

By Dr Troye Wallet

Sir Richard Branson is an unlikely introvert. When he started Virgin, he realised that companies are uninteresting to the media. So, he changed his public persona and became the outgoing, adventurous and extroverted man he is today — all for a story in the paper. Because everyone loves heroes: they are held up as leaders and celebrated and praised. Leaders such as Steve Jobs and Elon Musk become known because of the companies they build. Steven Marshall and Brendan Murphy have climbed the political ladder to leadership. Every doctor and healthcare professional gains the 'leader' label due to their training and respected position.

## GREAT LEADERS NEED A GREAT TEAM

The thing is, a leader is nothing without their team.

The Tour De France is the biggest bike race in the world, and the winner is considered the best cyclist of the time. However, no matter how fast a cyclist is, they cannot win the Tour without a top team. The team protects their leader, gets them into position in the group and rides in front of them, which decreases the effort needed to maintain their speed. Due to the necessary tactics, the complexity and the elements of the bike race, you cannot win as a single rider.

And so it is the team that should be celebrated, but it is the winner who stands on the podium and receives the glory.

## HOLDING UP AND TEARING DOWN

Leaders are held up all around us and are praised — in the good times. But a cultural shift is happening. Praise is becoming less common; blame and shame are becoming more prevalent. There is something about the age in which we live that leaders are vilified rather than glorified. When times become hard, and the correct decisions are not clear, leaders are dragged through the dirt. It seems instead of loving their heroes, people now love to hate them.

It is especially prevalent in our current time when decisions are not easy, there is no apparent right answer, and the road ahead is unclear.

American author Professor Brené Brown talks about 'the FFT'. The first F is an expletive, and for the sake of this article, we'll call it 'the Flipping First Time'. The idea is that the first time something is done, it will be hard, it's supposed to be hard, mistakes are supposed to be made, and it is supposed to feel awkward and uncomfortable. Framing FFTs in this way releases the tension of doing something new, as it normalises the discomfort. She says the pandemic is forcing us to do and think about a lot of things for the first time. It's not surprising it's rough, and that the answers aren't clear. There is no black and white. And the people leading us through this are experiencing the same feelings and lack of certainty as the rest of us. Perhaps some grace is required, rather than blame.

## BLAMING SYSTEMS, NOT PEOPLE

But when mistakes happen, when the wrong decision is made, who is to blame? Is the pilot the one to blame when the plane crashes? Is the surgeon to blame when a swab is left in the abdomen, or the incorrect surgery is done? Is the physician to blame when an obvious diagnosis is missed or the incorrect medication is given to the patient? Is the nurse to blame when the wrong IV is put up? Is the politician to blame when a decision has negative consequences?

They could be, but another way is to look at the systems surrounding the errors and blame the systems. This is not to say that people are not accountable for their actions, but rather that we understand human nature and establish systems that are less likely to allow human flaws to manifest themselves.

Looking at the systemic nature of behaviour and errors is empowering at every level.

## USING A SYSTEMS APPROACH

At a personal level, systems thinking recognises that self-control is overrated and doomed to fail. Instead of shaming ourselves because we are not strong enough to resist that chocolate, we understand human nature and create an environment to maximise the chance of success. It shifts the focus from the individual to the environment and systems that lead to the behaviours. Removing all treats from the house and a shopping list makes keeping to the diet easy.

In his book *The Happiness Advantage*, Shawn Achor introduces the concept of activation energy. The idea is that every action requires energy to initiate it. He tells the story of wanting to set up the habit of playing his guitar every night. No matter how hard he tried, he found himself watching TV instead. His solution was to remove the batteries from the remote control — increasing the activation energy required to watch TV — and to put his guitar next to the couch, decreasing the activation energy to playing. That way it was easier for him to practise guitar than watch TV — a system created to encourage the desired outcome.

Systems thinking works at a professional level, too. For example, if the doctors in a practice all have lunch scheduled at the same time, the environment generates opportunities for them to all be in the lunchroom at the same, which fosters brainstorming, collaboration and teamwork. Human nature is very predictable and generally will take the path of least resistance. If excellence is desired, set up the workplace or a system to encourage learning. When errors occur, rather than demanding change or extra vigilance from people involved, examine the system and the human flaw that led to the failure. Then a change can be made to prevent it from happening again.

***... Instead of shaming ourselves because we are not strong enough to resist that chocolate, we understand human nature and create an environment to maximise the chance of success ...***

In cities, alterations to design change behaviour more than public information campaigns. To encourage walking, make the footpaths wide and accessible. As a thought experiment and using Adelaide as an example, if the goal is to be the healthiest and fittest city in Australia, there are two options. The first is a massive public awareness campaign that demands changes to behaviour among people resistant to making them. Or, as a second option, Adelaide could create more bike paths. Building tunnels under the roads that cross the parklands makes cycling around the city easy, safe and encourages activity. People will naturally walk more, and runners will circumnavigate the city. Average exercise would increase because the city supports it. Even better would be to make the roads into tunnels and have a beautiful natural strip of land around the entire city. But that is just dreaming.

Environmental and urban design changes the behaviour of the people living there.

## A CALL TO ACTION

This is a call to action. A call to support our leaders, hold them accountable when necessary, but realise that decisions are not clear, and the correct path is hard to walk. A call to set up the conditions for good things to thrive and to set up the conditions that turn leaders into heroes. Because we need heroes now. Because we need the courage to be those heroes.

# With old school manners

## Dr Malcolm Alfred Wheaton

1924 – 2020

*Dr Malcolm Alfred Wheaton*

### *'Travelling the extra mile'*

As the only general practitioner at the busy Booleroo Centre practice in the southern Flinders Ranges, the late Dr Malcolm Alfred Wheaton had a reputation for having a heart of gold and never saying 'no' to the many and varied requests that characterised his 37 years in the role.

Just like the United States postal worker who vows, 'Neither snow nor rain nor heat nor gloom of night stays these couriers from the swift completion of their appointed rounds', Dr Wheaton was renowned for going the extra mile for patients.

Booleroo Centre is a small town in South Australia's mid north, 266 km north of Adelaide and about 70 km north-west of Peterborough, well-served by the Booleroo Centre and District Hospital. Dr Wheaton famously traversed the flooded Booleroo Creek, shoulder deep in water, and guided through to Booleroo Whim on a rope, travelling on to reach a gravely ill patient north of Willowie, 25 km north of Booleroo Centre. Unphased by the call to brave the floodwaters, Dr Wheaton left his car on the side of the road and crossed safely, going on to visit the patient who was later transported to Booleroo Centre. Happily, the ambulance travelled via nearby Melrose, Wilmington and Pinda Bridge rather than via the creek.


Dr Wheaton's car might have been the only casualty of the event but for a passing friend moving it from the flood water that had surrounded his car.

Dr Wheaton's service to the people of Booleroo Centre and nearby farms and towns began when he arrived in a blue Morris Oxford as a single man in 1956. Originally from Redhill, Dr Wheaton studied medicine after returning from World War II and set up practice in Booleroo Centre. He became a local, marrying Heather, a nurse at the Booleroo Centre and District Hospital, in 1963 and they later had four sons.

Like many country medical families, they lived at the practice where Dr Wheaton consulted Monday to Friday. The role seeped through the pores between work and home life as he was on call 24 hours a day. Farming provided his outside interest.

Dr Wheaton visited patients at any time of day or night for those who were too sick to see him at his consulting rooms. He also operated and delivered babies around the clock. In the traditional manner of country general practice, nothing was too much trouble.

Yet, as Mrs Wheaton says now, this was 'simply what you did in those days'.

'He did what all the doctors in neighbouring towns did; it was something they were trained to do,' Mrs Wheaton says. 'The patients came first. You saw patients when they needed to be seen and it was very rare that you sent them to Adelaide. There were specialists who were very helpful in providing support when it was needed.'

Dr Wheaton worked hard for the community, supporting local clubs and as the medical representative on the Booleroo Centre Hospital Board. He was awarded life membership at the Booleroo Centre & District Ambulance Service and is widely acknowledged as a generous, dedicated, thoughtful, kind and wonderful man.

Indeed, the plaque mounted on the renovated outpatient and theatre/recovery area in 2002 is dedicated to Dr Malcolm Alfred Wheaton, acknowledging his work for Booleroo Centre and District Hospital between 1956 and 1993.

So, it was not because he was not well-loved by staff and the community that nurses reported hiding from him in the pan room during his hospital rounds. The same determination and dedication that drove him to work tirelessly in the role was also reflected in his commitment to training nursing staff.

Dr Wheaton kept student nurses on their toes, quizzing them on the meaning of medical diagnoses. If they didn't know the first time, he would ask them again the next day. One nurse recalled that she can still recite the definition of shingles verbatim, having revealed she had no idea about the disease when he first asked her and was equally blank the second day after spending all night in the local pub. What he taught you, you learned for life, students noted.

While eminently professional, with 'old school manners', Dr Wheaton adopted some of the pragmatic, laid back approaches to problem solving characteristic of rural people. For instance, he and his family sometimes loaded his father's wheelchair into the back of a ute to bring him home for visits from the nursing home. As was the practice of the time, his father would be in the wheelchair and one of the boys would be holding onto it to ensure he did not fall out during the trip.

Dr Wheaton remained closely connected to the Booleroo Centre community throughout his life.

He lived to the great age of 96 and is survived by Heather and three of his sons.

*Pictures and information supplied by Dr Wheaton's colleagues, family and friends.*

# A fine innings

**Dr Dean Southwood AM**
MBBS, DLO, FRACS

1936 – 2020

*Dr Dean Southwood*

Dean Southwood AM made a significant and distinguished contribution as an innovator and committed teacher in facial plastic surgery.

To the outside observer his career path in medicine seemed logical. Yet as a young man, Dean dreamed of becoming a professional golfer and was persuaded to follow in the medical footsteps of his father Harry, a GP turned psychiatrist — if only as a back-up plan.

Dean was passionate about sports – he was a golfer and captain of the Prince Alfred College tennis and chess teams – and was an avid reader. He joined the Norwood Chess Club and, at his peak, was able to play the game blindfolded. But this played second fiddle to his love of the Norwood Football Club where he was an avid supporter all his life.

Dean was born on 16 May 1936 and lived on South Terrace in the city, where his father ran a general medical practice. He married Margaret, a tutor and researcher at the University of Adelaide while completing his final year of medicine at the same university.

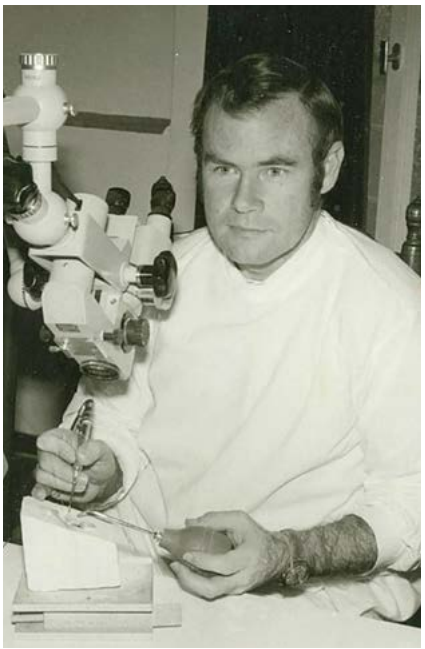
Not to be diverted from sporting pursuits by study, he continued to excel at billiards, snooker and table tennis, winning a South Australian amateur billiards title and contributing to three team championships, and writing a bidding system for bridge.

Nonetheless, Dean discovered a passion for ear, nose and throat (ENT) surgery during a rotation at the Royal Adelaide Hospital and, for the first time, knew exactly what he wanted to do. Study was no longer a chore and he spent many hours learning and teaching in a field that he enjoyed.

In 1985, Dean agreed to establish the Otolaryngology Unit at the Modbury Hospital, where he remained until his retirement in 2015. He initially faced challenges in attracting doctors who saw Modbury as a long way from the RAH and home, but over time the department became widely recognised as one of the country's best teaching units. The Dean Southwood Temporal Bone Laboratory, which he personally funded, attracted students from all over Australia and New Zealand. This remained the sole laboratory for all Adelaide registrars until 2019 and included a comprehensive ENT library with audio-visual and fixed dissections.

For some years, Dean organised and taught at Modbury's popular biennial national temporal bone dissection courses, which still remain popular.

Dean's dedication to registrar training was legendary. He was a long-time member of the State Registrar Training Committee and its chairman for many years. He served as the South Australian branch chairman of the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Section chairman from 1987 to 1988.



Dean's colourful personality, diplomatic mindset and fine skills made him a strong advocate for the profession and he organised many high-level conferences and cadaver and live dissection courses, with top speakers. He helped to build a bridge between ENT and plastic surgery and was captivating in his enthusiasm for otolaryngology and rhinoplasty. He was a wonderful teacher and mentor, hosting pie and pastry tutorials and tennis at his home. Dean was particularly fond of treating children and was known for his child-friendly manner, which included a well-honed coin-out-of-the-ear trick.

Dean developed strong links with esteemed members of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), which formed the seed for the development of the Australasian equivalent. He became the Founding President of the Australian Academy of Facial Plastic Surgery in 1990 and was widely regarded by esteemed founders of American facial plastics. He helped establish similar organisations across the world and was invited to become World Chairman but declined, believing Australia was just too far away from the rest of the world. He strived to ensure Australian students were part of this international

community, however, using a gift from his mother's estate to fund a scholarship for ENT students to attend a professional course in Bordeaux that he had particularly enjoyed.

Sporting and card contests remained a strong theme throughout Dean's life and the family home revolved around them. The tennis court was resurfaced with 'Gabba Grass' that accommodated a broader range of sports and the backyard was converted such that a card room opened onto an 18-hole putting green.

Dean followed all sporting clubs that wore the red and blue colours. The Norwood Football Club recognised his life-long contribution with life membership and named the family area at The Parade in his honour.

In the summer months, his interest turned to the East Torrens District Cricket Club, where he was president and later a life member. He famously insisted on a firm stance against sponsorship of that club by tobacco companies, personally offering a significant donation if the club would refuse tobacco company sponsorship. He then established a foundation that was formally supported by 1,500 doctors from around the country. The foundation raised so much money it was able to build a state-of-the-art clubhouse with the proceeds. His actions, and the accompanying furore, played an important part in achieving national anti-tobacco legislative changes.

Dean was a very gifted artist and enjoyed reproducing works of the great masters to the extent that when the family visited the impressionist paintings at the Jeu de Paume in Paris, his six-year-old daughter noted that the gallery had copied Dean's work. He developed a love of classical music and all things French, as well as movies that he studied with the same enthusiasm he brought to his work.

In 1992 Dean was awarded a Member of the Order of Australia for his services to ENT and the anti-smoking lobby. Initially he didn't want the recognition, but he eventually agreed to accept the honour after considering the time and effort that others had put into his application. With typically careful consideration, he eventually decided it was in the best interests of his profession and the cause.

*Dr Southwood followed the red and blue*

Dean was an outstanding contributor to the medical profession, his specialty and the sporting community. As his son Ian noted: 'He gave tirelessly and generously and was always a man of principle, even under the most testing of circumstances. He understood the value of persistence and hard work and was deserving of the rewards he received in life.' He is remembered by the medical profession as a father figure responsible for training hundreds of grateful young surgeons.



## NOTICES

**RICHARD HAMILTON MBBS, FRACS, plastic surgeon**, wishes to notify colleagues that his private clinic Hamilton House Plastic Surgery was fully re-accredited under the rigorous Australian National Standards (NSQHS) for health care facilities and also by the American Association for the Accreditation of Ambulatory Surgical Facilities International (www.AAAASF.org).

Richard Hamilton continues to practise plastic and reconstructive surgery at Hamilton House, 470 Goodwood Road Cumberland Park with special interests in skin cancer excision and reconstruction, hand surgery and general plastic surgery. He also conducts a 'see and treat' clinic for elderly patients with skin cancer. Convenient free car parking is available.

Richard also consults fortnightly at Morphett Vale and McLaren Vale as well as monthly at Victor Harbor and Mount Gambier/Penola. He is available for telephone advice to GPs on 8272 6666 or 0408 818 222 and he readily accepts emergency plastic and hand surgery referrals.

For convenience, referrals may be faxed to 8373 3853 or emailed to admin@hamiltonhouse.com.au. For all appointments phone his friendly staff at Hamilton House 8272 6666. www.hamiltonhouse.com.au

**The International Spine Centre® (TISC) is hiring!**

We are looking for dynamic practitioners to join our interdisciplinary team. Do you meet the 'if' criteria? *If* you are passionate about embracing change in health care practice, delivering collaborative care & putting patients first then we are the organisation for you. *If* you are drawn to teamwork & academic achievement, then consider TISC. *If* you have a desire to grow personally and clinically through interdisciplinary discussions, mentorship, research & hands-on theatre experience, then please apply.

Spinal Clinician (SClin) expanded practice GP roles & clinical psychology roles are available. It is our desire to further your career.

Contact: Eleanor Clausen CEO to discuss further. eclausen@theinternationalspincecentre.com

**Plastic surgeon Dr Peter Menz** wishes to inform colleagues of my forthcoming retirement. The Oxford Day Surgery Centre practice at Unley will close in mid-September 2020. I have enjoyed managing our patients there for more than 30 years, and I am grateful for the referral support over this time that has enabled this to happen.

**ANTHONY PISANIELLO MBBS PhD FRACP, interventional and structural cardiologist**, advises that he has returned from subspecialty training at Manchester Royal Infirmary, UK and The Johns Hopkins Hospital, USA, and commenced practice at Calvary Adelaide Hospital and Adelaide Heart Clinic, 32 North Terrace, Kent Town. He welcomes referrals for all cardiac conditions and has particular expertise in complex coronary intervention and transcatheter aortic valve implantation. Ph: 8362 6731. Fax referrals to 8362 2724.

# In the cockpit

The innovative Mercedes-Benz GLB SUV provides a myriad of fun surprises, writes Dr Robert Menz.

Mercedes-Benz is one of the world's oldest car companies and has always been at the forefront of innovation, particularly around issues of safety. Innovation also brings new models to the market – in this case, the GLB. GL in 'Mercedes speak' refers to the range of SUVs and, as you would logically expect, the B fits in size between the established A and C models. If you want a larger SUV, Mercedes also has GLE and GLS models corresponding to other E and S models in its range.

The test GLB was the mid-range all-wheel-drive 250 4Matic. It features a 2L, 165kW turbo petrol engine matched to an eight-speed automatic. The entry level 200 has a 1.3L 120kW power plant and drives through the front wheels. In case 165kW is insufficient, there is a GLB 35 AMG (AMG is 'Mercedes speak' for sporty) with the same basic engine retuned to deliver 225kW.

Many contemporary cars, especially in the luxury field where Mercedes plays, are bristling with safety and comfort features and an increasing array of driving aids as well. More of these later.

So, what is special about the GLB? The most striking external feature is the somewhat upright stance, reflecting the inclusion of a third row of seats. Access to the rear seats does require a degree of dexterity and nimbleness but once seated there is sufficient room for a full-sized adult – at least for a short trip. With seven seats in use there is limited storage space, but the boot size is quite adequate when set up as a five-seater.

The test car had a panoramic glass roof (optional in the 200) with a small section above the middle row seats and a large electric opening section over the front seats. The second row of seats was set a little higher than the front seats, giving passengers excellent visibility.

Sliding into the driver's seat reveals a very comfortable and multi-adjustable driving position both for the seats and steering wheel. A memory function allows the driving position to be set for the usual driver and, for those chilly mornings, the front seats are heated.

What used to be called a dashboard is now called a multimedia system with wide-screen cockpit. There are two adjacent 10.25-inch digital screens that can be customised. I left the test vehicle set up with digital instruments including speedo and odometer in front of the driver and used the second screen for ancillary functions. These can be accessed either directly using the touchscreen, by using the small touchpad in the centre console, or by using some steering wheel-mounted buttons

It would take several days to learn all the functions accessible through the touch screen; they include multimedia, including AM, FM or digital radio; telephony; navigation;

and air conditioning. There are also several USB ports. Connecting my iPhone through Bluetooth was simple and meant I could play my own music through the car system if I wished. There is a wireless phone-charging pad in the console.

One of the fun adjustments allowed me to change the ambient interior lighting to one of a wide range of fixed colours or to change subtly through a 'rainbow' function.

Mercedes also has a voice recognition system called 'Mercedes me,' which is activated by saying 'hi, Mercedes'. This worked well for telephone, navigation and even changing the radio station. The navigation system includes live traffic updates.

The mechanism to engage drive or reverse is no longer in the centre console but is on a stalk to the right of the steering wheel, and there are paddles either side of the steering wheel if you want to change gears yourself. Indicator lights and windscreen wiper functions are in the left stalk. The multifunction steering wheel includes controls for cruise control and speed limiter as well as volume adjustment for the sound system

As would be expected, the B-sized SUV is very easy to drive. While there are much sportier Mercedes, the GLB has more than adequate acceleration to keep up with or even pass traffic. Although not measured on this road test, the claimed 0-100km/p/h acceleration takes only 6.9 seconds (5.3 if you opt for the AMG model).

More importantly, the B feels quite solid on the road and, when it comes to breaking, stops very quickly. If there is a dangerous situation ahead, there are built-in safety mechanisms that activate the brakes before the driver has a chance to do so, thus avoiding potential collisions. Again, this function was not tested!

Testing involved a range of driving experiences. City driving was a breeze, and parking was very easy courtesy of the information on the central screen. The rear camera shows you the view immediately behind, but when you turn the steering wheel, a pair of orange lines appears on the screen predicting exactly your path while reversing. There is also a 'helicopter' view, which shows adjacent obstacles, kerb position and the white lines delineating a carpark, allowing precision parking.

Country driving was similarly straightforward. Adequate power and AWD made for comfortable cruising. The GLB was certainly competent through the curves, but the high centre of gravity was noticeable.

***… While there are much sportier Mercedes, the GLB has more than adequate acceleration to keep up with or even pass traffic …***

The cruise control maintained the nominated speed, even with relatively steep downhill driving. However, it is not adaptive, which is a surprise; adaptive cruise is available as an extra in one of the several option packages, in this case a nearly $2,000 option that also includes a driver assistance package, lane-change assist and extended automatic restart in traffic. The lane-change assist also provides a helicopter view of the car showing the relative location of vehicles in other lanes.

A day trip to Victor Harbor was rewarded with an easy view of southern right whales less than 400 metres from the beach. Fortunately, we did not have a flat tyre, as there is no spare. The run flat tyres are good for at least 80 km.

We also managed two trips to the Adelaide hills, including transporting Dr Phil Harding and his wife Margie to afternoon tea at FRED Eatery in Aldgate. And the following evening Patricia and I had a fireside pre-dinner drink at the Bridgewater Hotel. The GLB was quiet at highway speed with little road or wind noise and I imagine reasonably economical given that 1600 rpm equated to 110km/p/h on the freeway.

I asked Mercedes about the target market for this car and certainly doctors with young families would be a predictable market, especially if there is a need to occasionally carry extra passengers. I was initially surprised when told that a number of older couples are buying GLBs as touring cars, although realised this makes sense as it is possible to flatten the middle row of seats.

How much would you need to pay for all this innovation, safety, comfort and prestige? The listed retail price is just under $74,000, and the test car drive-away price a little over $87,000 including on-road costs and one or two options including colours other than white or black.

The test car was made available by Mercedes-Benz Unley. If you are interested in having your own test drive call the sales staff on 8408 4333 (or 8152 5000 if Mile End is more convenient).

---

*Dr Robert Menz is a GP and enthusiastic driver.*

# Polling place

Friends and colleagues joined AMA(SA) President Dr Chris Moy and his wife, fellow GP Monika Moy, at the AMA(SA) offices at Fullarton on 1 August to share the news – good or bad – of his Federal Vice President election bid.

Former AMA(SA) Presidents Dr Janice Fletcher, Dr Philip Harding and A/Prof William Tam were among those who 'socially distanced' as they watched and participated in the online National Conference proceedings, which included the elections of Dr Moy and new Federal President Dr Omar Khorshid.

*Dr Chris Moy and Dr Monika Moy*

*A/Prof William Tam and Dr Philip Harding*

*(From left) Professor Ted Mah, AMA(SA) Vice President Dr Michelle Atchison, Dr Philip Harding, Dr Monika Moy and Dr Ekta Paw*

*Dr Hannah Szewczyk, Dr Jemma Wohling and AMA(SA) Executive Board Chair Dr John Nelson*

## DISPATCHES

### WE'RE HERE FOR YOU

The AMA(SA) thanks members for providing ideas, views and feedback, and for alerting us to matters of concern, during the COVID-19 pandemic. Your involvement has been essential to ensuring we have been able to respond appropriately as issues emerge and continue to affect doctors, health practitioners, the wider health sector and communities.

The AMA(SA) is working closely with SA Health and other organisations to communicate the latest information to doctors and health practitioners across South Australia, and to ensure that emerging concerns are addressed.

Please note that due to the fire that damaged AMA House on 6 May, AMA(SA) staff are now working from offices at Level 1, 175 Fullarton Road, Dulwich.

Our phone numbers and email addresses remain the same. Our postal address remains PO Box 134, North Adelaide SA, 5006.

Email: admin@amasa.org.au or membership@amasa.org.au

Phone: 8361 0100

### SEPTEMBER COUNCIL MEETING

The next meeting of the AMA(SA) Council will be held on Thursday, 3 September 2020.

Any member wishing to attend the meeting, which will be held via Zoom, should contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au.

### FREE MEMBER WEBINAR FROM HOOD SWEENEY

If you're a Doctor in Training, early on in your career, or wanting to understand your financial situation better, you may wish to join the next free webinar to be staged by our partner Hood Sweeney. The one-hour webinar, 'Setting up your financial future', will be held on 8 October at 6.30 pm.

Topics include what you should know about tax, the basics of superannuation, and key principles of financial health.

To register, please contact Rebecca Hayward at membership@amasa.org.au or on 08 8361 0108.

### DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

If your contact details, place of employment or membership category has changed recently, perhaps because you're no longer a student, you're working part-time, or you've recently retired, please let us know so we can update your details.

If you've been a student member but are no longer a student, please let us know so we can upgrade you to a full membership. You'll then have access to a range of additional state and federal benefits, including the *Medical Journal of Australia* (valued at more than $400) and the AMA List of Medical Services and Fees (valued at $499), which are not available to student members.

If you have any questions about your membership please contact us at membership@amasa.org.au.

### DOWNLOADING YOUR TAX RECEIPT

Are you having trouble logging on to update your details, renewing your tax-deductible membership for 2020, or printing your tax invoice? Here's a simple tip to help:

- Head to: members.amasa.org.au
- Username: your email address
- Password: whatever you have set this as.

**To access your tax invoice:**

- log into your SA Membership Portal as above
- click on 'My Payments' tab
- click on 'AMA Membership Fee' next to the relevant date
- click on the PDF icon to download a copy in PDF format.

You can also update your contact details and payment information using this portal.

### ACCESSING THE AMA FEES LIST

Existing members can access the latest AMA Fees List at no cost at https://feeslist.ama.com.au/. Non-members can also purchase an annual subscription for $499.

# You've done more documenting than David Attenborough for this career.

# It deserves expert protection.

**120 years' experience** helping medical professionals

**Medico-legal advice** 24/7 emergency support

**Risk education** learn to manage your risk

**Earn Qantas Points**[1] on your MIGA insurance

With 120 years as a specialist insurer to the medical profession, protect yourself with the experts in medical indemnity insurance.[2]

**For a competitive quote, call 1800 777 156 or visit www.miga.com.au**

**The experts in medical and professional indemnity insurance.**

*Doctors, Eligible Midwives, Healthcare Companies, Medical Students*

miga ALWAYS

❶ A business must be a Qantas Business Rewards Member and an individual must be a Qantas Frequent Flyer Member to earn Qantas Points with MIGA. Qantas Points are offered under the MIGA Terms and Conditions (www.miga.com.au/qantas-tc). Qantas Business Rewards Members and Qantas Frequent Flyer Members will earn 1 Qantas Point for every eligible $1 spent (GST exclusive) on payments to MIGA for Eligible Products. Eligible Products are Insurance for Doctors: Medical Indemnity Insurance Policy, Eligible Midwives in Private Practice: Professional Indemnity Insurance Policy, Healthcare Companies: Professional Indemnity Insurance Policy. Eligible spend with MIGA is calculated on the total of the base premium and membership fee (where applicable) and after any government rebate, subsidies and risk management discount, excluding charges such as GST, Stamp Duty and ROCS. Qantas Points will be credited to the relevant Qantas account after receipt of payment for an Eligible Product and in any event within 30 days of payment by You. Any claims in relation to Qantas Points under this offer must be made directly to MIGA by calling National Free Call 1800 777 156 or emailing clientservices@miga.com.au
❷ Insurance policies available through MIGA are underwritten by Medical Insurance Australia Pty Ltd (AFSL 255906). Membership services are provided by Medical Defence Association of South Australia Ltd. Before you make any decisions about any of our policies, please read our Product Disclosure Statement and Policy Wording and consider if it is appropriate for you. Call MIGA for a copy or visit our website at www.miga.com.au 

AMA
SOUTH AUSTRALIA

# FOR YOU, YOUR COLLEAGUES AND ALL SOUTH AUSTRALIANS

## WE ARE STRONGER IF YOU ARE WITH US
## WE ARE LOUDER IF YOU SPEAK THROUGH US
## OUR INFLUENCE IS GREATER WHEN MORE OF YOU ARE BEHIND US

The AMA(SA) is proud of its long and proven history of supporting South Australia's doctors, and as a trusted advocate for the medical profession and the health of all South Australians.

Our value has never been more evident than in fighting COVID-19, when we've been pivotal in:

- Contributing to plans to stop the spread of COVID-19
- Introducing telehealth MBS and electronic prescribing
- Providing financial and mental health support for doctors
- Advocating for adequate PPE
- Supporting Doctors in Training and medical students.

**DECISIONS ARE MADE BY THOSE WHO SHOW UP. SUPPORT THE ORGANISATION THAT SUPPORTS YOU.**

# JOIN NOW!

SA.AMA.COM.AU
MEMBERSHIP@AMASA.ORG.AU
08 8361 0108