medicSA

AUGUST 2019

VOLUME 32 NUMBER 4

EXAMINING END-OF-LIFE CHOICES

THE NEW TEAM
NEW CHIEF EXECUTIVE, NEW VICE PRESIDENT

A NEW PRESCRIPTION

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AMA
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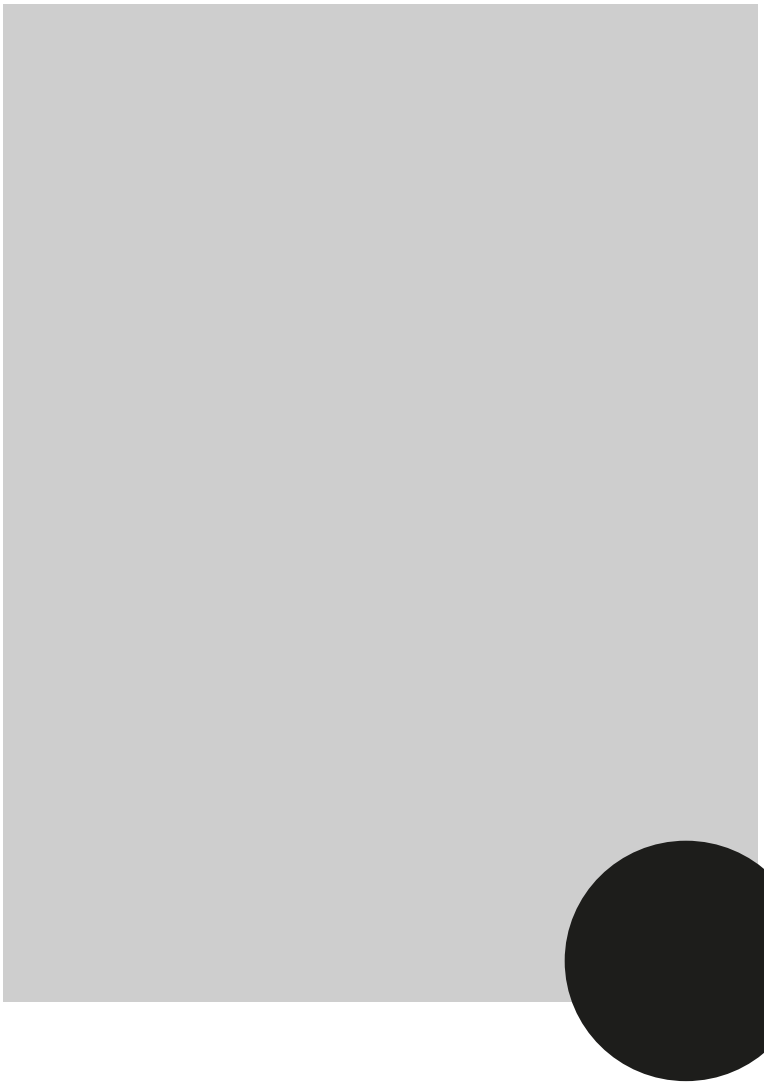

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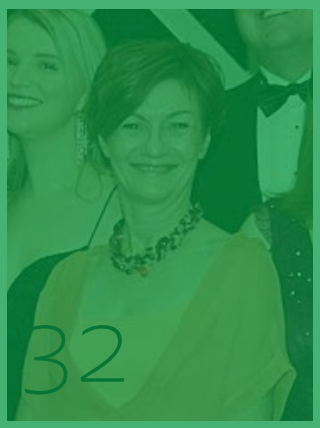
VISION
NEW AMA(SA) PRESIDENT: WHAT IT IS TO BE A DOCTOR
At the 2019 AMA(SA) Charity Gala Dinner, our new AMA(SA) president Chris Moy explained his vision for the AMA(SA) – and why he loves toy stores so much.

UPDATE
GENDER EQUITY SUMMIT 2019
Gender inequity does exist in medicine. Those who attended the AMA Gender Equity Summit in Sydney recently found it helped with understanding why. By Hannah Szewczyk.



NATIONAL CONFERENCE
IMPRESSIONS OF A 'NEW RECRUIT'
The AMA National Conference is a stage for debating what the medical profession's future can and should hold, as AMA(SA)'s new media advisor discovers. By Karen Phillips.

REFLECTION
TIME – THE DANCE OF PRIORITIES
What are your priorities? What do you value most? Time slips by fast, so consider how you spend it, and spend it wisely ... by GenWise co-founder Troye Wallett.

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DR CHRIS MOY
PRESIDENT'S REPORT

YOUR AMA(SA): LET'S HEAR YOUR VOICE

... The quality of doctors' education and training is essential to a high-performing health system ...

If anyone needed convincing that the Australian Medical Association enjoys a rare status as a trusted source of opinion and advice about the state of the health system and how it can be improved, my diary of the past two months might provide ample evidence.

In recent weeks, I've been asked to provide comments for media coverage of issues as varied as influenza deaths and vaccinations, the use of ICE in South Australia, My Health Record, and whether mobile phones should be banned in train stations to stop people scrambling on to tracks to retrieve them. I've been asked to join my Queensland counterpart, Dr Dilip Dhupelia, as he fronted a parliamentary inquiry into voluntary assisted dying and end-of-life law reform. I've spoken to national journalists about how dangerous it is for patients to turn to social media for 'expert' medical advice.

I recount this activity not to suggest that I am 'in demand'. What is in demand, however, is the sensible, science-based advice of Australia's most important advocate body for doctors and for patient health. The unprecedented prevalence of influenza across Australia and the impact on health resources are examples of how health and medicine affect the lives of all Australians, and it is critical that we have been asked to provide our perspective and advice on these issues. It demonstrates that the knowledge and expertise of our profession and our members is recognised and appreciated.

The role of president must be more than just one of explaining often complex issues to the public, however. The AMA(SA) has been asked to submit our thoughts and ideas to government and other entities about a range of subjects in recent months – among them, a new plan for 'ageing well' in South Australia, early childhood immunisation, abortion, and variations to 'Gayle's Law'. The abortion and Gayle's Law submissions were particularly important, as they posed questions about how individual members viewed matters relating to their values and ethics as well as practical and legal considerations. While the Federal AMA's position statements on such issues give us a very strong foundation for the opinions the AMA offers governments and other entities, I am also extremely conscious of the need to submit documents that are inclusive of the often varying views of our members here in South Australia. In this regard I thank all members who provided input into these and other submissions, and I hope to soon expand the avenues through which members may contribute.

The subject of thanks brings me to another very important topic. We have recently announced the appointment of a new chief executive officer, Dr Samantha Mead, who joins us on 7 August and who explains her vision for the AMA(SA) on page XX. But when the AMA in South Australia suddenly required a new leader in February, it was Council member Dr John Woodall who readily stepped in. As acting chief executive officer, John brought calm leadership, strong governance principles and immense knowledge to the office and our organisation. On behalf of the Board, staff and all members, I thank John for his selfless service. We are indebted to him.

EDITOR'S LETTER

DR PHILIP HARDING

Who'd be a whistleblower – but where would we be without them?

In 1847, Ignaz Philipp Semmelweis first drew attention to the high incidence of frequently fatal puerperal fever in maternity clinics, where doctors and students came straight from the autopsy room to examine patients in the clinic wearing their filthy aprons and without washing their hands. His proposal for the practice of hand washing with disinfectant solutions, and subsequent demonstration that this drastically reduced the mortality rate, was ignored and ridiculed by the Viennese medical community of the day, and thousands of women continued to die until his practices gained acceptance many years later in the days of Pasteur and Lister.

In the March 2019 issue of *medicSA*, we reviewed Adelaide ophthalmologist Prof John Compton's book on his father David Crompton's crusade in the 1950s, drawing attention to the incidence of blinding eye infections associated with the use of non-sterile eyedrops. Again, there was resistance to change from the established professional and bureaucratic bodies of the day, but eventually his findings were accepted and led to national and international change.

In this issue, on page XX, we publish Prof Brendon Kearney's review of the book *Infected Blood Products: Australia's Greatest Medical Disaster* written by Adelaide anaesthetist Richard Davis. It is a riveting story: make sure you read it. More of the same. Thousands of people internationally contracting Hepatitis C or AIDS as a result of flawed practices and vested interests.

This trilogy of catastrophic iatrogenic infections over two centuries contains a message: could such a thing happen again? Probably. History seems to have a habit of repeating itself. Just watch out for the sound of blowing whistles.

TACKLING SUICIDE RATE

Government appoints new National Suicide Prevention Adviser.

The current CEO of the National Mental Health Commission has been appointed as the Federal Government's National Suicide Prevention Adviser.

Christine Morgan will work with Health Minister Greg Hunt and the Department of Prime Minister and Cabinet on a whole-of-government approach towards preventing suicide.

In making the announcement, Prime Minister Scott Morrison said he was committed to taking all necessary action to tackle the suicide rate, and ensure Australian families, communities and those facing challenges get the support they need.

"I am particularly focused on continuing our strong support for those most at risk, including our veterans, Indigenous Australians and young people," the Prime Minister said.

"Suicide is the leading cause of death for young Australians, accounting for over one-third of deaths among younger people aged 15-24 years. The prevalence of suicide among Aboriginal and Torres Strait Islander people is around twice that of non-Indigenous Australians.

"Providing greater support for all Australians needing mental health and suicide prevention services is a key priority of my Government."

EMPOWERING PATIENTS TO TALK ABOUT MEDICAL FEES

The AMA has released a new guide to empower patients with important information to help them understand medical costs.

The new guide – *Informed Financial Consent: A Collaboration Between Doctors and Patients* – aims to give patients confidence to discuss and question fees with their doctors.

The guide – co-badged with more than a dozen leading medical Colleges, Associations, and Societies – was launched at Parliament House in Canberra by Health Minister, Greg Hunt in July.

AMA president, Dr Tony Bartone, said the Informed Financial Consent (IFC) guide is a major step in helping to build health financial literacy for health consumers.

"The IFC guide will provide people with clear, easy-to-understand information to help them navigate the health system," Dr Bartone said

"It will help patients in their conversations with doctors and practice managers about fees for their medical procedures.

"It will empower them to ask questions – the right questions.

"The whole IFC process will provide information that will give patients and their families greater comfort and security as they go into surgery or treatment.

NT COLLECTS 2019 DIRTY ASHTRAY AWARD

The NT Government has been judged to have been the worst-performing Australian government on tobacco control measures over the last 12 months.

This year is the 25th anniversary of the National Tobacco Control Scoreboard – run by the AMA and the Australian Council on Smoking and Health (ACOSH) – and the Northern Territory has managed to collect the dubious Dirty Ashtray Award 13 times.

In contrast, the Queensland Government has achieved a remarkable hat trick by topping the scoring to win the coveted National Tobacco Control Scoreboard Achievement Award for leading the nation in tobacco control measures.

Federal AMA president, Dr Tony Bartone, released the results of the AMA/Australian Council on Smoking and Health (ACOSH) *National Tobacco Control Scoreboard 2019* at the National Press Club in Canberra on 24 July.

Dr Bartone congratulated Queensland on its strong consistent record in stopping people from smoking, and urged the Northern Territory to build momentum with its efforts on tobacco control, while noting the NT Government had amended and strengthened its tobacco control legislation earlier this year.

"The Queensland Government has continued to protect its community from second-hand smoke in a range of outdoor public areas including public transport, outdoor shopping malls, and sports and recreation facilities," Dr Bartone said.

"Queensland Health is well ahead of other health services in recording smoking status, delivering brief intervention, and referring patients to evidence-based smoking cessation support such as Quitline.

"The *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 – Policy and Accountability Framework* indicates a commitment to reducing smoking among Indigenous communities.

"Funding continues for the *B.Strong Brief Intervention* training program to strengthen primary healthcare services for Indigenous smokers.

"A dedicated smoking cessation website – QuitHQ – has been developed for the Queensland community, which includes quit support, information for health professionals, and smoking laws. Promotion of QuitHQ includes on-line messages and billboards."

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?????

SA JOINS STATES EXAMINING END-OF-LIFE CHOICES

The rumblings about whether South Australia needs new legislation relating to end-of-life choices has become louder since Victoria's 'assisted dying' legislation took effect in June.

AMA Queensland president Dr Dilip Dhupelia sought the support of AMA(SA) president Dr Chris Moy when he presented the Queensland branch's submission to the Queensland Government's Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying on 4 July.

The inquiry is examining what a voluntary assisted dying scheme could and should encompass in Queensland, including what safeguards must be considered and whether medical practitioners should be able to conscientiously object. Nearly 5,000 submissions have been received, many asking the Queensland Government to introduce the laws and have them debated before the next state election in October 2020.

As chair of the AMA's Federal Ethics and Medico-legal committee, Dr Moy told the inquiry that euthanasia gave doctors the power to become a select group in society, lawfully entitled to end life.

He said that while the current public debate was viewed almost entirely through the lens of an individual's right to 'choice', 'shifting the needle' towards legalised euthanasia posed a wider threat to vulnerable groups in the community, such as older persons or those with disabilities, where contemporary judgements about the value of life could be imposed.

"The bit that society does not understand is the potential for the introduction of values that are not what they were," Dr Moy told the inquiry. "And I think that is a real threat."

During the hearing, Dr Dhupelia noted that the AMA's Position Statement on Euthanasia and Physician Assisted Suicide 2016 says that "doctors (medical practitioners) have an ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity".

"This statement alone should provide reassurance to you and to the Queensland community that doctors will always be there to care for their patients until the end," he said.

Dr Dhupelia later told the media changes to the law could pose ethical conflicts for doctors. He said if VAD was legalised, he would be very concerned about securing protections for doctors who conscientiously object to delivering a lethal injection.

"Our job is to actually save people's lives," Dr Dhupelia said. "It is very difficult for doctors to be faced with a situation where they've got to provide lethal injection to somebody that they've been looking after for 15, 20, 25 years.

"Doctors are people too. And they became doctors to actually save people's lives and do the right thing. So, it's a difficult situation."

Within days of Dr Moy appearing before the Brisbane-based parliamentary committee, the AMA(SA) received an invitation to submit its views about end-of-life choices to a Joint Committee of the South Australian Parliament.

Chaired by Kyam Maher, the committee includes David Basham, Sam Duluk, Dennis Hood, Mark Parnell and Tony Piccolo.

The Joint Committee's Terms of Reference indicate it has been established to inquire into and report on:

a) The practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care;
b) The current legal framework, relevant reports and materials in other Australian states and territories and overseas jurisdictions, including the Victorian and Western Australian Parliamentary Inquiries into end-of-life choices, Victoria's Voluntary Assisted Dying Act (2017) and implementation of the associated reforms;
c) What legislative changes may be required, including consideration of:
   i. The appropriateness of the Parliament of South Australia enacting a Bill in similar terms to Victoria's Voluntary Assisted Dying Act (2017); and
   ii. An examination of any federal laws that may impact such legislation;
d) Any other related matter.

The AMA(SA) has contacted members for their views and will reflect this input in the submission.

The AMA Position Statement on Euthanasia and Physician Assisted Suicide is available on the Federal AMA website.

VICTORIA'S VOLUNTARY ASSISTED DYING SCHEME

Victoria's voluntary assisted dying scheme (VAD) took effect on 19 June. It has 68 safeguards and strict criteria that applicants must meet before being granted permission to take the lethal drugs.

An applicant must:

- **have lived in Victoria for at least 12 months**
- **be aged 18 or over**
- **have two doctors agree the applicant has a terminal illness**
- **be assessed as being in intolerable pain that is likely to cause death within six months, or 12 months if the illness is a neurodegenerative condition such as motor neurone disease.**

Patients are provided the medication in a locked box, to mix themselves before taking the fatal dose.

WCH WISHLIST IS A FOCUS ON PEOPLE

AMA(SA) president Dr Chris Moy and vice-president Dr Michelle Aitchison joined other groups from across SA's service sector in a lock-up session to analyse the 2019 State Budget.

Pictured: After the Budget lockup: AMA(SA) president Dr Chris Moy, with Martin Haese from Business SA, Narelle Graham of ABC Regional Radio and producer Petria Ladgrove.

Later that afternoon and in the following days, Dr Moy was asked to provide an AMA perspective on the Budget to audiences of the ABC, The Advertiser and South Australian television stations.

Dr Moy expressed a view that while there were no nasty surprises, the Budget had a clear emphasis on infrastructure spending but no equivalent commitment for improved resourcing of people-focused services and programs.

He said he was happy that the Budget provided funds to begin development of the new Women's and Children's Hospital (WCH) and thanked the State Government for honouring its election commitment.

As he told Advertiser journalist Brad Crouch, in comments published in a feature article about the WCH on 2 July, Dr Moy said the AMA had long advocated for a new WCH to be co-located with the Royal Adelaide Hospital (RAH).

"Our wish-list for the new hospital is more about process than 'things'," Dr Moy said.

"Firstly, that the design of the hospital focuses genuinely on people – patients and the doctors and nurses who care for them – rather than being a grandiose and expensive idea built on the concepts of consultants. And in focusing on people's needs we obviously don't want less – no loss of services, no loss of beds – and the position next to the RAH should be used to advantage.

"Along these lines, we have spoken to Minister Stephen Wade and emphasised that the lessons of the new RAH build must be applied, the main one being that, this time, doctors and nurses must be genuinely involved in the design of the hospital at all stages."

Examples of poor planning included emergency cubicles at the RAH that are too small and where doctors and nurses have no line of sight to observe patient, he said.

"This is an example of structural problems that are now only overcome by the dedication and ingenuity of staff," Dr Moy said. "Having real clinicians decide how large a room needs to be, or what equipment is required, would seem to be common sense. And it might also save a great deal of money, with a good example being the new Calvary Adelaide Hospital on Angas St, which employed this principle and which although offering about half the beds of the new RAH is slated to come in at a great deal less than half the cost.

"Finally, the AMA(SA) is aware it will be several years before the new hospital is open. We must not 'take our eye off the ball' in making sure that the staff providing care at the current WCH site are supported with adequate resources to continue and improve the care of our women and kids in the interim.

"For example, Minister Wade is aware of our concerns about some of the persistently long waiting lists for children to be seen in outpatients where, for example, the delay in an appointment for a child with suspected multiple sclerosis currently runs into years.

"The doctors of the AMA(SA) are committed to helping design a new hospital that is less about a flashy building than it is a place that the people of South Australian can be proud of because of the quality of care they receive there."

NEW AMA(SA) CHIEF EXECUTIVE: DR SAMANTHA MEAD

Dr Mead, most recently CEO of the Australian Dental Association in South Australia has joined the AMA(SA) as our new chief executive.

AMA (SA) president Dr Chris Moy said Dr Mead had emerged as the outstanding candidate from a large field of applicants with medical, governance and leadership, and business expertise.

"Samantha comes to us with considerable and recent experience in leading a membership and advocacy organisation with similar values and missions as our own," Dr Moy said.

"This experience, her science and management qualifications and her roles in not-for-profits and SA Health will be invaluable as Samantha takes on a position critical to the AMA's capacity to advocate for better health outcomes for all South Australians."

Before joining the Australian Dental Association, Dr Mead was CEO of SIDS and Kids South Australia, state manager SA/NT of the Australian Veterinary Association, and a senior executive officer with SA Health.

Dr Mead's academic qualifications include a PhD awarded for research at Flinders University and Oxford. During her post-doctoral fellowship at the (US) National Institutes of Health she contributed to the understanding of how DNA damage and repair mechanisms affect human health.

She holds a Diploma of Management from the Australian Institute of Management and is a graduate of the Australian Institute of Company Directors.

Dr Mead said the position provided an outstanding opportunity to make a significant and positive impact on South Australian healthcare.

"The AMA(SA) plays an important and highly respected role in educating and advocating for healthcare improvements across the community," Dr Mead said.

"Throughout my career I have chosen to work to improve the quality and safety and health of individuals and communities. I look forward to using my skills and experience to enhance the success of this influential and unique membership organisation."

"My philosophy is basically about getting the job done and getting it done successfully. Training as a scientist, I tend to try again and again until I get things right. l do that by working with people – I'm very much a people person. You can't be successful in a role like this and work in isolation. People need to want to do well – they need to understand the vision and we all need to be going in that direction."

"My plan is to contribute to membership by absolutely taking every opportunity I can get. And I also plan to ensure the Association runs like a well-oiled machine – that staff are capable and happy, and that I have the support of Council."

Outside of work, Sam loves the great outdoors and escaping to the shack her grandfather built on the Yorke Peninsula.

"My whole family loves the shack. It is certainly not glamourous and is probably only one step up from camping. My husband, two children and two dogs – we love it. It doesn't have a phone, there's no computer, but you do have clear reception when you stand at the top of the nearby sandhill ... it's a real getaway for us."

FAREWELL TO AMA(SA) COUNCILLOR

The AMA(SA) would like to wish Dr Heather Cain a fond farewell, as she leaves South Australia for new ventures in New South Wales. Heather was craft group representative on AMA(SA) Council from 2013 to 2016.

Heather spent the last 30 years working in both the public and private pathology systems in South Australia and the Northern Territory. She has worked at The Queen Elizabeth Hospital, Flinders Medical Centre and the Women's and Children's Hospital, where she was a consultant chemical pathologist. She has most recently worked in a group private practice.

Dr Chris Moy met with Heather to say farewell on behalf of the AMA(SA) in later June. Heather will be xxxxxxxxxxx xxxxxxxxxx xxxxxxxxx xxxxxxx xxxxxxxxxx xxxxxxxxxx xxxxxxxxxxx. We wish her well in her new ventures.

MEET YOUR NEW VICE-PRESIDENT: DR MICHELLE ATCHISON

The AMA(SA)'s incoming vice-president is a private psychiatrist who works with patients suffering the effects of trauma, including the impacts of war service. In this article, she tells us about her background, life and medical career.

BY DR MICHELLE ATCHISON

I was born in England while my parents were working overseas. My father was a political cartoonist and worked in London for *Punch* magazine. My sister and I were born there and came back to Australia on the slow boat through the Suez Canal. We settled back in Adelaide, eventually in the Adelaide Hills where I grew up and did my schooling at Heathfield High School. Schooling there taught me a lot about life and diversity. I had schoolmates who were everything from the farmer's children to the children of doctors. I believe this helped my grounding in psychiatry, where being able to talk to people from all walks of life is a useful skill.

I grew up in a very arts' focussed home – we had an art gallery in the house for most of my childhood. This again brought me into contact with a group of people – artists – who were fascinating and very alternative.

My school went the extra mile for myself and other academic achievers. When I said I'd like to do French and Art on top of the 'top five' subjects in Matriculation, they made it happen – even though I was the only Year 12 French student. I did well enough to choose what I wanted to do at university, so Medicine it was, much to the bemusement of my family who had no medical connections. My younger sister went on to do Law – again a source of bemusement.

I chose Flinders University because it was the progressive medical school and allowed students to spend a quarter of their time in the first four years in a discipline outside of medicine. This meant I could do Visual Arts, and later Spanish, along with my medical degree. After finishing, I was drawn to Psychiatry. It is a branch of medicine where you are allowed to understand the whole person, to use medicine along with the 'art' of psychiatry and to truly make a difference to the lives of my patients.

I started an aborted academic career and then went into private practice psychiatry. I have a passion for private practice and believe the AMA has lost some of its way in supporting these practitioners. The focus on public practice and the major changes there has taken the focus off private practice. Proposed MBS changes, challenges to private health insurance and the business of private practice all mean that private practitioners need the support of the AMA. I agreed to the vice-president position to bolster the voice of private practice and of psychiatry. The mental health of our patients and of doctors themselves is one of the most important areas the AMA must support.

To balance private practice, I have had a long association with the Royal Australian and New Zealand College of Psychiatrists, as an examiner, a member of a number of committees and as the chair of the SA Branch for six years. I am currently the chair of the College's Section of Private Practice Psychiatry.

I am married to another psychiatrist, which is a source of great distress to our daughter, who thinks we 'psychoanalyse' her all the time. We don't! We have two big poodles, two cats, and often my daughter's Maremma dog at home. This makes for a lot of animals at times.

My interests include holidaying, playing bridge and reading a good book. I am a Crows fan, a *Game of Thrones* fan (not the last season) and an *Avengers* fan. I grew up in a house where *Monty Python, The Goodies* and *Doctor Who* were our TV of choice.

AMA(SA) DISPATCHES

AMA(SA) COUNCIL MEETINGS

Meetings of the AMA(SA) Council are open to all members. AMA(SA) Council meetings are held monthly, excluding the months of January, April, July and October.
The next meeting will be held on Thursday, 5 September at 7.00 pm.
Any member wishing to attend Council meetings should contact Claudia Baccanello on claudia@amasa.org.au or 8361 0109.

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We have an excellent array of seminars scheduled for 2019 and many more new events to come. Please see the link to our website, where you can view and book online at ama.com.au/sa/sa-events-seminars.

Don't forget to keep checking the page regularly so you don't miss out! Members are free, non-members $40

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This is the place to go when you want to find colleagues and specialists for a referral. It enables you to search for a doctor, anywhere in Australia, by name, address or discipline. The search provides a doctor's name, specialty, current practice contact details and a scalable map that can be printed and provided to patients. Go to doctorportal.com.au/find-a-doctor.

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Don't forget to add the #amasamember to your pictures so we can see them and share!

A NEW PRESCRIPTION FOR A PEOPLE-FOCUSED HEALTH SYSTEM

The AMA's Family Doctor Week took place in July, highlighting the importance of the patient-GP relationship. Here, our AMA(SA) president, writes about being a GP and how a healthcare system that is based on the needs of people is needed *now*.

BY DR CHRIS MOY

In Australia, about 90% of us go and see a GP at least once a year. We go for checkups, for prescriptions, for immunisations. We go because we have symptoms that trouble us, and we want a trained professional to give a diagnosis, treatment advice and perhaps a prescription, or a referral to a specialist, or tests, or all three.

We go because in this country, we consider our GPs to be the starting place – our 'go to' – for the healthcare we need and expect from our health system.

I am extremely fortunate to be one of South Australia's GPs. I enjoy that rare privilege of being trusted diagnostician, healer, adviser and confidante, for patients at my surgery and in aged care facilities.

But it's becoming tougher. More of our patients are older, and come to us with often complex physical needs. More come to us to discuss mental health issues – sometimes not even knowing that it is a mental health issue at the root of their discomfort or physical pain. More come from culturally and linguistically diverse communities, and in some cases, and for no fault of their own, it takes longer for us to understand their problems or how best to care for them in culturally acceptable ways.

At the same time, like everyone else, we are being asked to do more with less, or sometimes are not supported at all. For example, GPs who care for older residents in aged care facilities have no financial support for all of the critical non face-to-face work and time which can make the difference in care, such as a phone call to arrange treatment or to family. One of those phone calls – to a registered nurse who is then able to begin treatment or provide pain relief, for example – can prevent a hospital admission and a great deal of patient distress, as well as save the health system thousands of dollars.

We GPs watch as governments spend billions of dollars on hospitals while hesitating to spend money on the preventative campaigns that might stop people going to hospital. We watch as aged people who want to die peacefully at home are shuffled between their homes and hospitals, because the funding for GP coordinated community-

based care is insufficient.
We watch as some of our rural colleagues struggle to receive the federal support they need to attract new talent and continue to provide essential services to the communities that depend on them. And we watch with despair as more than 700,000 avoidable hospital admissions occur each year in a health system that seems happier to fund a patient to make a $600 emergency department visit than adequately support a GP through Medicare to provide a consultation which might avert such a visit.

Australia has one of the world's better health systems. But the way it is funded is becoming more and more illogical and upside down.

My colleagues and I want to write a new prescription – a prescription for a healthcare system that is based on the needs of people, and offers care where and when Australians want it: at home, in our communities, before we are stricken with illnesses with severe consequences for ourselves and the economy.

NEW AMA(SA) GENERAL PRACTICE COMMITTEE

The AMA(SA) is seeking nominations from members with expertise in general practice to join the AMA(SA) General Practice Committee.

"The AMA provides a powerful platform for advocacy, policy and leadership across health," Dr Moy said. "We need to allow GPs to harness this influence in improving the state of health of South Australians.

"The AMA(SA) will formalise this contribution by reintroducing a sub-committee of our Council with special interest in general practice medicine and its role in building and promoting healthy individuals and communities."

As a GP, Dr Moy said patients were often surprised to learn that general practice is a specialty area that requires three to four years' specialist training – almost 10 years from the beginning of medical school.

"General practice is incredibly rewarding – but also requires a wide knowledge of every aspect of medicine, so we can help our patients understand their physical, psychological and emotional issues, relieve their anxiety, and guide them towards the best care.

"And although we sometimes lose sight of it, GPs have a unique place in the lives of our patients in walking them through the journey from cradle to grave, with all its joys and sorrows."

Dr Moy said the Council sub-committee would enable the AMA(SA) to have a formal avenue through which GPs could highlight pressing concerns and decide on advocacy approaches on key health issues in South Australia.

"The committee aims to restore, and build on, a similar AMA(SA) Committee existing prior to 2016," Dr Moy said.

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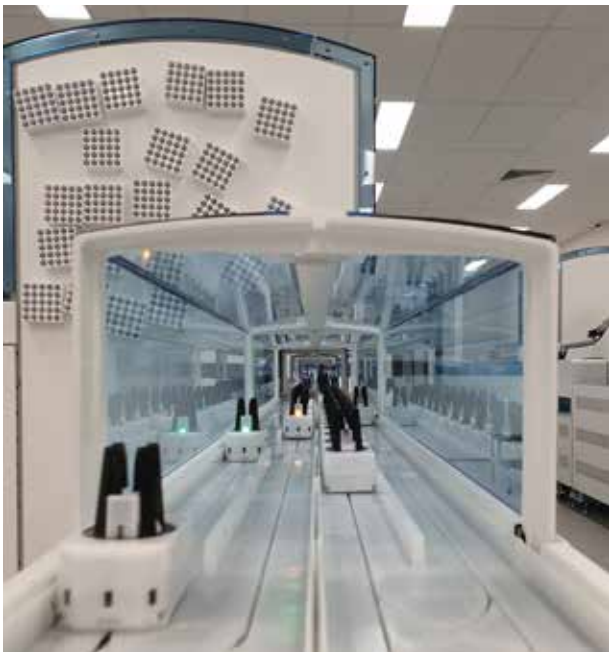
FULL STEAM AHEAD FOR ADELAIDE'S WORLD-FIRST PATHOLOGY TECHNOLOGY

As more people need more tests, the efficiency of pathology laboratories becomes more and more important.



South Australia's Clinpath Pathology has ensured it is ready to address ever-larger workloads by investing in new technology to streamline its workflow. Clinpath's new Mile End laboratory the first in the world to install an Abbott Alinity triple module chemistry platform with a GLP track – complicated language for a system that sorts and analyses blood samples at super speed, and which looks like a giant train set.

"Efficient pathology tests are essential for a high-quality health system," CEO Dr Fergus Whitehead said. "About 70% of medical decisions and 100% of cancer diagnoses rely on pathology tests."

Clinpath Pathology is a private pathology practice that provides laboratory services to general practitioners, specialists, private hospitals and aged care facilities in SA, and is part of the Sonic Healthcare group. The new technology transports samples via cars to pre-analytical devices including bulk loader, centrifuge, de-capper and aliquoters, before they are sent to state-of-the-art analysers.

Sonic Healthcare managing director Dr Colin Goldschmidt said the purpose-built laboratory and equipment would foster interdisciplinary collaboration and medical problem-solving.

"A lab like this – staffed with experienced, high-quality and passionate pathologists and staff – is equipped to provide outstanding medical service to the people of South Australia," Dr Goldschmidt said.

"This lab embodies our 'medical leadership' philosophy and stands as a model of excellence in Australian and international pathology.

"It is a philosophy that has pathologists and laboratory professionals intimately involved in all business operations and decisions. It is a model designed to deliver optimal patient care, one that places the needs of patients at the centre of the highest standards of medical care."

At the opening of the facility on 31 May, the Governor of South Australia, His Excellency the Honourable Hieu Van Le, acknowledged the impact of scientific advancements on the wellbeing of South Australians.

"Pathology plays an integral role in ensuring better diagnosis of medical conditions, and the best possible patient outcomes," His Excellency said. "In my own experience and in the experience of my friends and family, such information has been crucial for treatment and positive outcomes."

AMA(SA) president Dr Chris Moy and immediate past president A/Prof William Tam joined His Excellency on a tour after the opening.

"I'm mesmerised by the speed at which the technology automatically sorts the specimens," Dr Tam said.

Dr Chris Moy described what he saw. "Individual samples dropped into a drawer in a bulk load are quickly sorted to ride atop individual cars running along tracks reminiscent of 'Scalextric' toy-car tracks of my childhood,' Dr Moy said. 'These cars then follow complex individually determined journeys through various analysers to obtain results.

'This truly state-of-the-art technology is a credit to Clinpath Pathology and a statement of its commitment to serve the South Australian community.'

Clinpath has invited medical practitioners see the technology in action during a 30-minute tour. To book a tour visit clinpath.eventbrite.com.

PRIVATE HOSPITALS PLAY IMPORTANT ROLE IN WIDER HEALTH SYSTEM

In this article, medicSA reports on the latest developments at Adelaide's private hospitals.

AMA(SA) VISITS PARKWYND PRIVATE HOSPITAL

AMA(SA) president Dr Chris Moy and acting CEO Dr John Woodall witnessed first-hand the beneficial role small private hospitals play in the wider health system when they visited Parkwynd Private Hospital recently.

"Our visit left us convinced that smaller 'bespoke' healthcare organisations complement the resources provided by larger hospitals and organisations," Dr Woodall said.

Located on East Terrace in central Adelaide, Parkwynd offers a range of general and surgical specialties for adults and children, including orthopaedic, oral and maxillofacial, otorhinolaryngology, plastic and reconstructive, and ophthalmology.

Parkwynd has 23 patient beds, a 12-chair day surgery unit and three operating theatres. Staff say its size is one of Parkwynd's greatest strengths, allowing them to deliver consistent and personal services.

Orthopaedic surgeon Dr Rob Atkinson, who has enjoyed a long association with Parkwynd, said small hospitals often attract and retain talented staff.

"The regular staffing of small hospitals is a consideration for patients and medical officers, as the loyalty to the hospital is normally high in comparison to the larger facilities," Dr Atkinson said.

In addition, he said, there may be a lower risk of infection.

"The larger the hospital, the more patients, which in turn means there is a much greater use of medication, particularly antibiotics," he said.

"All things being equal, a small hospital like Parkwynd does not seem to have that same level of risk. In my experience at Parkwynd, being a smaller facility there seemed to be a lower level of infection – and if there was infection, the bacteria tended to be those in the community and not the highly resistant 'superbugs' as noted in larger hospitals."

Parkwynd general manager Sue Coe thanked Dr Moy and Dr Woodall for accepting the invitation to visit Parkwynd.

"We appreciated the opportunity to showcase our facility, which allowed them to observe firsthand the personalised approach we provide and meet with members of our Medical Advisory Committee and staff," Ms Coe said.

She said Parkwynd publishes data on the My Healthscope website, which measures the safety and quality of its services.

"This is only one part of our program to continually maintain and improve our high standards," Ms Coe said. "It reflects our commitment to our patients, staff and specialists and we are able to boast a healthcare acquired complications rate (HAC) of zero."

NEW CALVARY ADELAIDE HOSPITAL: 2020

In early 2020, the new Calvary Adelaide Hospital will open, integrating the existing services provided by Calvary Wakefield Hospital and Calvary Rehabilitation Hospitals.

The new Calvary Adelaide Hospital offers increased bed capacity, positioning it as SA's largest private hospital – comprising 12 stories, 344 beds inpatient beds, specialist cardiac, neurosurgical and orthopaedic services, as well as general surgery and bariatric surgery.

General medical, rehabilitation and geriatric beds will also be available. Calvary is committed to providing care for people with medical conditions: often beds for these people are difficult to find in the private sector. Two floors will be dedicated to rehabilitation services, including a state-of-the-art hydrotherapy pool and adjacent mobility garden. Plans are also underway for a stroke clinic which will be the first of its kind in the SA private sector.

Two floors are dedicated to operating theatres and procedural suites, including a hybrid theatre, this will more than double current operating capacity at Calvary Wakefield.

The only 24-hour private emergency department will continue to provide South Australians with an option to avoid potential long public waits for emergencies and urgent care. The hospital will be home to a large number of specialists who have chosen to take up tenancy in the new building to provide easy access for your patients to specialist consultancy and treatment.

Pictured: AMA(SA) acting CEO Dr Woodall (left) and president Dr Chris Moy (fifth from left) with Parkwynd Private Hospital director of nursing Mardi Andersen, business development manager Monica Dillon, general manager Sue Coe, Dr Rob Atkinson, Dr Margaret Anderson, perioperative manager Sarah English and Dr Natesan Lakshmanan.

It is the intention to move current services in January, and undertake a short period of settling in. Once new workflows are established and staff are feeling comfortable in the new environment, the increased capacity and growth period will begin.

Calvary's investment in the new Calvary Adelaide Hospital, along with ownership of its other hospitals – Calvary North Adelaide and Calvary Central Districts – and services such as Calvary Flora McDonald in Adelaide, Calvary St Catherine's Retirement Community in Berri, and Calvary Community Care (home care service) is a statement of confidence in the SA state economy and Calvary's ongoing commitment to providing for the long-term health needs of South Australians.

EXPANSION AT ST ANDREW'S HOSPITAL

On 30 April 2016, St Andrew's commenced work on a major expansion referred to as the Eastern Clinical Development (ECD). The development includes a day surgery facility with 35 recovery beds containing two operating theatres, three procedure rooms, two angiography suites, a 28-bed cardiac ward, a staff gymnasium, a new and relocated Central Sterile Supply Department and a three-level carpark, two of which are underground.

The Eastern Clinical Development has been operational for over 18 months now and is working extremely well. Feedback from medical specialists, staff and importantly patients has been outstanding. From an operational perspective, despite some initial teething problems, all areas are now operating with a high degree of efficiency and effectiveness. Careful planning and consultation proved to be worthwhile as the project was completed on time and within budget. In fact, since the completion of the project St Andrews has won a number of architecture, building and design awards.

ASHFORD HOSPITAL UPGRADE

Ashford Hospital commenced a $33 million upgrade in December 2017, with many project milestones already achieved including: an additional operating theatre, upgrades to existing operating theatres and recovery; replacement of mechanical services (air conditioning) and upgrades to fire systems; refurbishment of the main entrance with a new reception area; creation of a new six bed Chest Pain Unit and a new Sacred Space on the first floor; upgrading and expansion of the Day Procedure Unit from 14 chairs to 30

chairs; and creation of a new street-front cafe on Marleston Avenue. Additionally, new patient accommodation has been opened on the first floor, including a 24-bed ward 'Unley' ward.

The development was designed to expand clinical services and facilities, improve the patient experience and assist the ongoing energy security of the hospital. The opening of the new areas has been positively received by staff, specialists and patients. It is expected to be complete by March 2020.

NEW ADDITIONS AT FLINDERS PRIVATE HOSPITAL

Flinders Private Hospital strives to provide the best in private healthcare and service provision for its community. Some recent additions to its service and upgrades to the facility include new cardiac angio equipment in all three angiography labs, which continue to undertake the majority of interventional life-saving procedures in the south; and a new consulting suite for the Colorectal Consulting Group (suite 209, Level 2 of the Hospital).

This incorporates the new Rapid Access PR Bleed Clinic which offers a streamlined service for patients requiring diagnostic investigations associated with PR bleeding, designed to shorten the time to diagnosis in treatment for patients with suspected lower gastrointestinal malignancy. A GP referral is essential for a fast-tracked appointment – phone 8371 3077.

Neurosurgery is a new specialty commencing later this year at Flinders Private Hospital, expanding the services for southern patients and providing access to neurosurgical and spinal surgery. In addition, there are now nine operating theatres (two cardiothoracic theatres), one procedure room and three angiography labs on the procedural floor on Level 3.

REDEVELOPMENT AT THE MEMORIAL HOSPITAL

The Memorial Hospital's redevelopment commenced in November 2018 with an expected completion date of April 2020. Works being performed include: an additional operating theatre (now eight in total) and upgrade of the perioperative suite; a dedicated Paediatric Day Stay Unit with 15 beds; a new 3-storey building which will include new staff amenities, PDSU and theatre; refurbishment of 65 patient beds; expansion and upgrade of CSSD, in line with AS/NZS 4187:2014 standards; reconfiguration of the main kitchen; and improved infrastructure throughout.

The redevelopment is focused on ensuring the outstanding care The Memorial Hospital's patients experience occurs in conjunction with modern facilities, aesthetically pleasing surrounds and beautifully landscaped gardens. The works will be completed in line with the beginning of the Centenary Celebrations as The Memorial Hospital commemorates its 100th year of caring for South Australians.

BACK ON THE WALL

Following the move of AMA(SA)'s headquarters from its historical place in Newland House to the second floor of AMA House, many members were concerned about the fate of the portraits, honour boards and other memorabilia which adorned the old offices, including the Council room.

Well, the good news is that, on the initiative and under the supervision of interim CEO John Woodall, these have now been hung in the new offices. There had been a general feeling that they simply wouldn't fit in the space, but the result is remarkable as shown in the accompanying pictures.

The board bearing the names of presidents from centuries past, the other with the names of all of the South Australian AMA Fellows, and the portraits of JC Verco, WT Hayward, F Wood-Jones, COF Rieger and Sir Henry Newland, along with Lord Lister, all look splendid in the positions found for them.

Anyone bringing visitors into the office now can be proud of the way our heritage is displayed and our thanks go particularly to John Woodall for achieving this.

How can we use the opportunity in our lives for the greater good?

ABUNDANCE OR SCARCITY MINDSET?

Both abundance and scarcity are simply a mindset – so be careful how you set your mind ...

BY TROYE WALLETT

DR TROYE WALLETT is a GP and the clinical director of GenWise Healthcare. He co-founded GenWise in 2014 and feels fortunate for the opportunities and abundance that allowed him to do so. He is happy to be contacted about any speaking or teaching opportunities: t.wallett@genwisehealth.com.au

Turn on the tap and water flows. Forget to turn it off, and it will never cease flowing. Supermarket shelves are full of food, most with excess calories. Rundle Mall is full of clothes, diamonds, electronics and telecommunications. All it takes is a few clicks of a mouse, and anything you want is yours.

The same abundance is true when it comes to opportunity. Gatekeepers are falling. Never before has it been so easy to write a book and self-publish it, make a movie and upload it to YouTube, or turn an idea into a business.

South Australian politicians are encouraging entrepreneurship. The old RAH site is becoming a hub of innovation. Anyone with an idea, drive and a work ethic can make their idea a reality. It is the golden age of opportunity.

ABUNDANCE MINDSET

Flavia Tata Nardini proves the point. She is the CEO and founder of Fleet Space Technology, an Adelaide-based space company founded in 2015. Incredible that an Italian-born engineer can found a space company here in South Australia and make such a global impact. She is not a billionaire. She is not a government organisation. She is a person with a vision and a plan. These days that is all it takes.

Flavia has an 'abundance mindset'. She realises that one is not restricted by what one has accumulated. Instead, she has the confidence and understanding to know that anything is possible. Viewing the world through that lens makes it vivid, exciting and full of possibility.

AT OUR FINGERTIPS

All the world's knowledge is at our fingertips. Wikipedia contains more information that can be read in a lifetime. MIT (Massachusetts Institute of Technology), one of the leading technology universities, publishes all of its lectures and courses online at no cost. An online dermatology website, Dermnet, has the mission statement to make authoritative information about the skin available to anyone in the world with an internet connection, and they do.

Our world is full of abundance – ready and waiting to be used.

Of course, we must acknowledge that our abundant world is also one of privilege. There are certainly people in Australia and in other countries who have far less. Even taking into account the access almost everyone in Australia has to the internet, there are people whose lives are hard, and who lack the mental and social space to take advantage of the resources around them. It is, therefore, incumbent on us to use the surplus of opportunity in our lives for the greater good, to create environments where all people can thrive.

In saying that, abundance is not the same as wealth. Wealth is a factor of net worth and what is owned, while abundance is about access and opportunity. Abundance is a mindset.

SCARCITY AND VALUE

Value and abundance are inversely linked. The more there is, the less value it holds. YouTube videos have very little worth because 300 hours of content

are uploaded every minute. Value lies in scarcity. A discussion of abundance is incomplete without considering scarcity. If basic needs, knowledge and opportunity are abundant, then what is scarce and valuable?

Knowledge is easy to come by, but skill and wisdom are not. If all medical information is accessible with a simple Google search, doctors are not valuable for their knowledge. Instead, their value is in the years of skill and wisdom they have accumulated gaining and applying the knowledge. Expertise, such as skill and wisdom, is scarce and valuable.

Trust is equally precious. Doctors are given an element of trust due to their title and being part of a trustworthy profession. Trust is like gold and is to be protected and maintained at all costs.

Attention is another scarce and valuable resource. It is easy to make a video or write a book. However, building an audience who care is challenging. Doctors' attention is sought after by every pharmaceutical company, every medical service and many other companies who vie for 10 minutes of our time. However, we are not unique. Facebook, Instagram and Google are in the attention business. Their business model leverages the scarce resource of attention and turns it into wealth.

SCARCITY MINDSET

Recognising scarcity is different than having a scarcity mindset. A scarcity mindset is one of hoarding and fear. Anxiety comes from the feeling that there is not enough of anything and possessions need to be guarded. The scarcity mindset is inward-looking and lacks generosity.

Both the abundance and scarcity mindsets are self-fulfilling.

They are two sides of the same coin. The modern world is undoubtedly a golden age of access and opportunity, which makes it harder to see what is valuable and scarce. Perhaps success has always been about recognising the abundant and leveraging it to build the scarce. Maybe having an abundant mindset is independent of the world around us and leads to a prosperous life, rather than the other way around. If that is true, a rich life is accessible to all of us. All it takes is to adjust the way we view the world.

Because being rich is about being generous and giving ... and being poor is about taking and hoarding.

Challenges of accurate subtyping and reporting of breast cancer

WHICH CANCER IS THAT AND DOES IT MATTER?

The breast pathologist of today is required to marry traditional morphological methods with immunohistochemical techniques.

BY WENDY RAYMOND

A/PROF WENDY RAYMOND is a consultant pathologist in private practice at Clinpath Laboratories, and at Flinders Medical Centre. She has a long-standing interest in breast pathology. She is a past president of the Australasian Society for Breast Disease and of the Australian Society of Cytology. She can be contacted at wraymond@clinpath.com.au.

The role of the pathologist as a 'diagnostic oncologist' in the subspecialty of breast pathology has changed substantially over the past 10 to 15 years, partly as a response to the refining of surgical techniques and partly due to a greater understanding of the range of molecular pathways which result in different pathological subtypes of breast cancer.

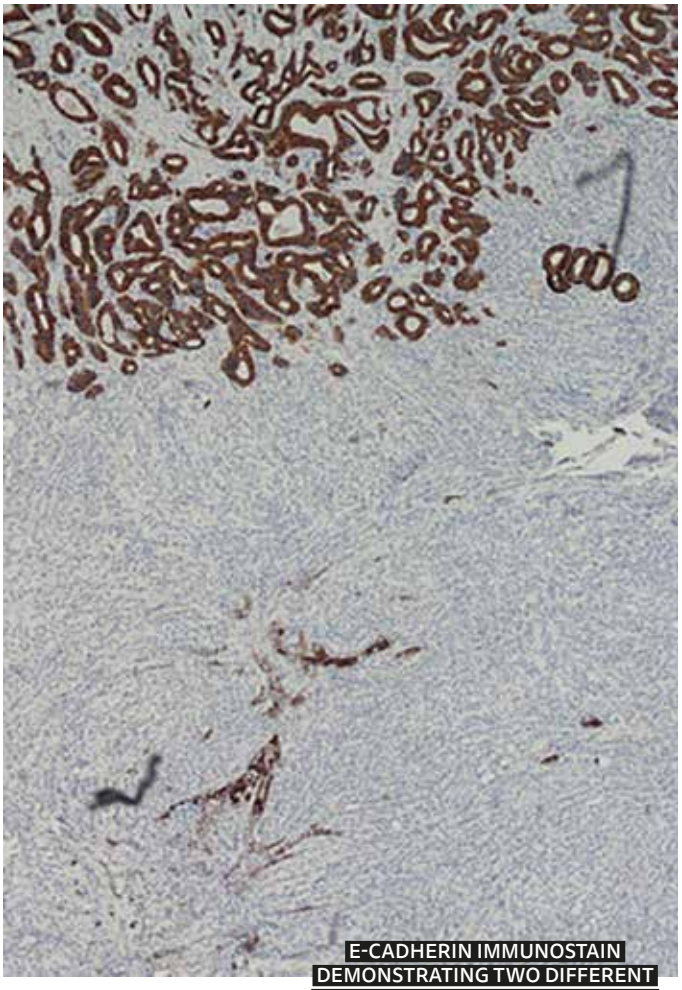
TRADITIONAL PROGNOSTIC MARKERS

Traditional prognostic markers remain of great clinical value in determining further therapy following a breast cancer resection and assessment of tumour size, histological type, histological grade (effectively an integration of biology and tumour genetics) and axillary lymph node status should be included in the routine diagnostic pathology report. Ancillary studies to assess and quantify the predictive tumour markers oestrogen receptor, progesterone receptor and HER 2 receptor are also assessed, as are measurements to the nearest surgical margins. Some clinicians also request an assessment of proliferation, such as a Ki67 count, although use of this marker is variable and controversial (see below).

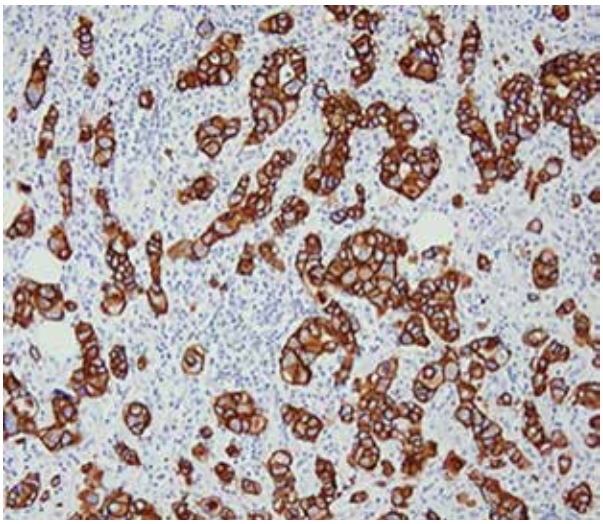
HISTOLOGICAL SUBTYPING

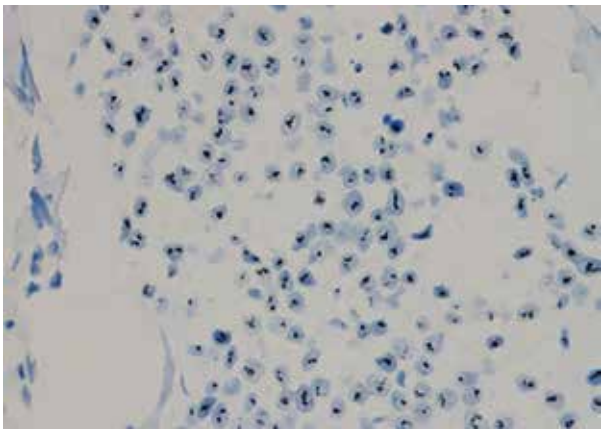
The WHO classification of tumours of the breast (IARC Press, 2014, Ed. S Lakhani et al) is a detailed morphological classification of subtypes, of which the most common is the invasive carcinoma of no special type (also called ductal or not otherwise specified), accounting for up to 75% of breast cancer diagnoses. Certain traditionally good prognosis subtypes are recognised and include tubular carcinoma, cribriform carcinoma and pure low-grade mucinous carcinoma, while poor prognostic subtypes include metaplastic carcinoma and inflammatory carcinoma. Certain immunohistochemical markers may be used to refine subtyping, however the problem faced by histopathologists is that the required 'cut-offs' (as to the proportion of cells expressing these markers) are frequently uncertain, or the specified 'cut off' is somewhat arbitrary. This naturally results in problems of reproducibility.

Traditional morphological typing into the two most common breast cancer subtypes (ductal and lobular) is mostly relatively straightforward, but in certain cases there is a degree of overlap and it can be difficult to determine if the tumour is ductal showing some features of lobular or vice versa. Pathologists report these cases as 'mixed ductal and lobular'. One consistent molecular alteration identified in lobular carcinoma and its variants is alteration of the E-cadherin adhesion complex, which is a mediator of epithelial cell interactions on the cell membrane. E-cadherin is recognised as a cell membrane stain immunohistochemically. Loss of E-cadherin staining is identified in approximately 85% of lobular carcinomas, with aberrant expression recognised in most of the remaining cases. This stain has led to recognition of a number of lobular carcinomas which are morphologically different from the more traditionally described



E-CADHERIN IMMUNOSTAIN DEMONSTRATING TWO DIFFERENT SUB-CLONES IN THE ONE TUMOUR.





A HER 2 – POSITIVE BREAST CANCER ON IMMUNOSTAINING (ABOVE) AND IN SITU HYBRIDISATION (BELOW)

subtype, including those with tubule formation or more marked nuclear pleomorphism (pleomorphic lobular subtype). However, it is somewhat simplistic to utilise E-cadherin immunostaining alone as a means of defining this subtype, as lobular carcinomas may express E-cadherin in a small percentage of cases and some poorly differentiated ductal carcinomas may lose this marker. In addition, patterns of E-cadherin staining, together with ER, PR and HER-2 staining, allow pathologists to recognise the presence of subclones within larger tumours and also differences between primary and metastatic tumour deposits.

NOVEL CLASSIFICATION METHODS – 'MOLECULAR' SUBTYPES

More recently a molecular classification of breast tumours has been recognised. This is based on gene expression profiles and the most widely accepted subgroups, which have prognostic relevance, are the luminal A, luminal B, HER-2 enriched and basal-like subgroups. Attempts at 'molecular classification' by immunohistochemical surrogates have been published but determination of immunohistochemical cut-points and standardisation has been extremely controversial, with up to 25% misclassification. This is particularly the case in the use of the proliferative marker Ki67 (MiB). Ki67 has a definite role as a prognostic marker in cohort studies, but its role as a predictive marker is less defined.

The broad group of carcinomas defined as 'basal-like' includes the 'triple negative' cancers (ER, PR and HER-2-negative), and is regarded to be at the poorly differentiated end of the spectrum. This group includes many of the BRCA 1 and 2 associated cancers but also encompasses a broad spectrum of morphologically and phenotypically different carcinomas with both good and poor prognoses. These cancers have been further classified into 4, 6 or 10 subtypes and include immunomodulatory (immune activation), mesenchymal-like and mesenchymal stem-like and luminal AR. Some authors also include salivary gland-like tumours and minimal ER (with basal-like phenotype). While these each have specific molecular profiles, it is not possible to absolutely and reproducibly determine these molecular subtypes on the basis of current histological methods or using immunohistochemical stains.

THE FUTURE

The breast pathologist of today thus is required to marry traditional morphological methods with immunohistochemical techniques and a degree of uncertainty in subtyping may at times reflect this difficulty. At present, therapy is largely driven by assessment of hormone and HER 2 receptor status and classification into different subtypes does not indicate specific therapies. However, the field is rapidly changing and new therapies may necessitate more precise classification. Gene expression assays are more readily available (although remain costly) and may help to refine future accurate subtyping of breast cancer.

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FOODBANK SA RECEIVES AMA(SA) SUPPORT

Each year the AMA(SA) supports a charity through funds raised at the annual Gala Dinner. This year, the nominated charity was Foodbank SA.

AMA(SA) president Dr Chris Moy presented Greg Pattinson, CEO of Foodbank SA – our state's largest hunger relief organisation – with a cheque for $10,000 at the Gala Dinner, held on Saturday 11 May at the Adelaide Convention Centre. In addition, another $2282 in raffle ticket sales was raised on the night for the charity.

Foodbank rescues edible but surplus food and groceries from the country's farmers, manufacturers and retailers. Without Foodbank much of this food would simply go to landfill. Over 560 charities and 460 schools can access the food and distribute it to adults and children in need as food parcels, school breakfasts, prepared meals and food hampers.

Supply doesn't always meet demand, however. In particular, there is a significant gap between the amount of staple foods rescued and what is needed by the charities to provide filling and nutritious meals. So, in a key staple program, Foodbank partners with food producers and manufacturers who donate ingredients and services in order to produce, process, package and transport essential items such as breakfast cereals, pasta and sauce and tinned fruit and vegetables.

"The funds raised by the AMA(SA) will allow Foodbank SA to provide enough food for nearly 25,000 meals to families who are doing it tough across SA," says Greg. "We can't thank the people who donated enough."

Financial contributions from the public and corporate sector provide essential funds to purchase essential key staple foods that cannot be obtained through donations.

If you would like to support Foodbank SA, you can find out more information at www.foodbanksa.org.au. Visits and tours of Foodbank's main warehouse operations are also welcome and can booked on 8351 1136.

AMSS HEADS INTO 'ANGRY AUGUST'

After a relatively quiet period in the AMSS calendar, students approach 'Angry August' looking forward to a busy schedule of events.

TOM GRANSBURY
STUDENT NEWS:
ADELAIDE UNIVERSITY

ADELAIDE EMC GRAND FINAL TEAM

'Angry August' is an affection term for the month where students look forward to the annual MedBall, inter-year and student-staff debating and begin rehearsing hard for MedRevue production. Pre-clinical students are returning from holidays, having completed their first exams for the year, and clinical students are well into their second semester and beginning to turn their focus to exams in November.

Reflecting on the past month, the AMSS' APYexchange was a great success and saw eight students heading out to the remote Aboriginal communities of Pukatja and Amata to run a school holiday program in conjunction with the NPY Women's council. Two more teams of students are preparing to head out in October. In July, almost 100 Adelaide students made the trek down to Hobart for the 2019 AMSA National Convention, where the University of Adelaide finished third (of 22 medical schools) competing for the Convention Cup. The Adelaide Emergency Medical Challenge Team, lead by their dedicated captain Evan Garrett, drew in the national grand final, against a considerably senior Western Sydney team and narrowly came second by judge discretion. The team should be congratulated on the result, and a huge thanks given to the Adelaide Simulation Team and many emergency doctors and trainees who helped the team in their intensive training schedule. Adelaide University also made the final for futsal, semi-finals for debating, and fiercely represented SA in the comedy debate on the topic that Tasmania should leave Australia.

Sixth-year students have recently received their first rounds of internship offers with all Commonwealth Supported Applicants from SA medical schools receiving offers, as well as many offers to interstate medical students. We are hopeful for our SA-trained international students receiving offers, two of whom have gained internships through the Rural Intern Pathway, and many others hoping for a place as students who have applied to multiple states withdraw from their offers.

AMSS advocacy branch Team Education has also been in full swing, with advocacy focusing around the moving of supervisor assessment forms online and modernising anatomy teaching. Student feedback on the new Mental Health First Aid courses has been extremely positive, resulting in a commitment from the university to continue running them, despite withdrawal of federal funding. The AMSS is also working to tackle bullying and harassment in the medical program. This has been a focus of the recent surveys informing the Australian Medical Council student report, with the aim of educate both students and staff to ensure all individuals feel safe at the Adelaide Medical School.

MENTAL HEALTH MONTH

Progress testing: strange effects

Here's an update on the goings-on of the Flinders Medical Program, and an insight into how the Progress Test is changing the way students learn medicine.

JARROD HULME-JONES
STUDENT NEWS:
FLINDERS UNIVERSITY

Final year Flinders students sat an online prescribing exam for the first time in June and July. The online exam has long been used by medical schools in the UK and asks high-quality case-based questions that get to the heart of the most common prescribing errors. Its use is an excellent step towards ensuring that all interns are safe prescribers.

On the social calendar, tickets have gone on sale for the annual Wright Evans Partners FMSS Ball, to be held in the Adelaide Town Hall with the theme 'Masquerade' – it promises to be a spectacular event.

Progress testing is having strange effects on Flinders students – particularly first years. The Progress Test – a 150 multiple-choice question, negatively marked, quarterly exam spanning all medical disciplines, sat simultaneously by all year groups – is pitched at the level of students ready to graduate with an MD. It follows then that many of the questions are on the management of conditions or nuances of their diagnosis rather than the anatomy and physiology that underlies them. So how does a first-year student, who is told to focus their energies on anatomy and physiology as the foundations of medicine, best their peers* in the Progress Test? The scenario we had hoped for was MD1s focusing on foundational knowledge and collectively gaining permissibly low Progress Test scores.

There are two powerful forces that are preventing this ideal scenario from playing out as intended. Firstly, postgraduate MD1 students often have health professional backgrounds that allow them to answer clinical questions that their peers cannot. Secondly, medical students universally passionately hate performing poorly in tests and will spend their first year optimising their scores over learning basic sciences.

The reality of assessment in MD1 therefore is this: if a student perfectly learns all the content they are taught in MD1 and correctly answers the 20-30 questions per test based on this knowledge, they may not pass the Progress Test because their peers have learned ahead, or came with prior knowledge, to answer questions beyond the MD1 curriculum. We have some problem solving to do.

**A student is deemed satisfactory, doubtful or unsatisfactory by comparing their Progress Test score with those of their peers.*

DISTINGUISHED PHYSICIAN, TEACHER AND ADMINISTRATOR

PETER MURRAY LAST OAM MBBS FRCP FRACP FRACMA

1929 - 2019

Peter Last, the locally best-known member of an eminent medical family, died on 5 July 2019 after a short illness. His own statement was that he was of Adelaide stock through and through, reaching back for five generations. He was the second child of Raymond Jack Last and Vera Estelle Augusta Judell. His parents separated when he was a toddler, so Peter and his elder brother John who subsequently became professor of Community Medicine in the University of Ottawa were brought up by their mother.

Peter's father had no direct influence on Peter's upbringing but went on to become professor of Applied Anatomy at the Royal College of Surgeons in London. By a bequest on his death, Peter's father enabled the establishment of the Wood Jones Chair in Anthropology and Comparative Anatomy at the University of Adelaide.

Peter was educated at Brighton Primary School and St Peter's College, where his athletic record was undistinguished, but he did well scholastically and went on to the University of Adelaide medical school from which he graduated in 1952 as the top student in his year. Between 1953 and 1956 he worked in clinical and laboratory positions in Adelaide and Melbourne, where he passed the MRACP examination. In 1955 he married Jennifer Mary Robertson, to whom he remained devoted for the remainder of his life. 1958 and 1959 saw him at the Hammersmith Hospital in London where he worked for eminent physicians including Dr (later Professor and Dame) Sheila Sherlock. On returning to Adelaide he worked at The Queen Elizabeth Hospital, where he was responsible for establishing renal dialysis in Adelaide, and became very involved in undergraduate and postgraduate teaching.

In 1961 he returned to Royal Adelaide Hospital, and began to develop his lifelong interest in clinical administration. He had a significant and long-lasting impact on hospital practice in SA through his commitment to high quality clinical records and maintenance of clinical discipline. He was also well known through his educational activities and care of sick nurses. In 1963 and 1964 he was a member of the State Council of the AMA, and in 1964 became senior specialist physician at Repatriation General Hospital, Daw Park, and honorary assistant physician at the RAH. He was much involved with direct patient care and clinical administration, as well as teaching, which brought him into contact with a generation of senior medical students and young doctors, especially those who aspired to become consultant physicians.

In 1972 he made a major career change, by virtually relinquishing clinical medicine to become assistant director general (medical systems) of the SA Hospitals Department. Over the next 11 years he was successively director, State Health Resources Unit, health services coordinator and medical coordinator in the SA Health Commission, which was established in 1977.

During these years Peter had a wide and varied influence on many aspects of policy formation within the health services, at both state and commonwealth levels, significantly influencing the development of country hospitals and other aspects of rural health services.

From 1983 until 1990 Peter returned to institutional administration as the inaugural clinical superintendent at Julia Farr Centre. Here he was directly responsible for major changes in professional standards and in enhancing quality of life for the residents of the largest nursing home in Australia.

In the Queen's Birthday Honours of 1991, he was awarded the Medal of the Order of Australia (OAM) for services to medicine.

Peter and his family have been enthusiastic yachtsmen, racing and cruising for many years. He was long-serving editor of the quarterly publication produced by Royal South Australian Yacht Squadron, and was elected to the rare honour of life membership of the Squadron in 1999.

Peter Last is survived by Jenny and his children Rob, Kate, Anne and Bill together with their growing families. He died peacefully in the Mary Potter Hospice surrounded by his family and will be remembered by generations of SA doctors as an outstanding clinician, teacher and administrator.

This obituary was compiled from Peter Last's own autobiographical notes. A further tribute to his work written by Dr Lu Mykyta appears on the next page.

MILITARY DOCTOR, MEDICAL ADMINISTRATOR, GP

DR ROBERT BRITTEN-JONES AO MBBS FRCS FRACS

1928 - 2019

Born on 9 June 1928 to mother Adeline and father Alan, Robert Britten-Jones spent his early years at Commonella – the family home on Prospect Rd, now Blackfriars School – where he lived a privileged life courtesy of his mother's family's wool cheques.

Bob was doted on by his aunts, Lena and Olive, who helped raise him after the tragic early death of his mother, when he was only six months old. Later his father remarried and had six more children.

At age 12, Bob became a boarder at Xavier College in Melbourne – continuing a family tradition of Jesuit education which had started with his grandfather at St Aloysius at Sevenhill in the Clare Valley. Bob considered himself fortunate to be going off to get a high-quality education which brought about a life-long connection with the Jesuits, built resilience, and paved the way for a successful academic and working career.

At 18, Bob returned to Adelaide to study medicine at the University of Adelaide, where he topped his final year of medicine and represented the university in rowing.

On his 21st birthday, he received from his mother's estate his interest in the entity which owned the Mundi Mundi station located west of Broken Hill and Wirealpa east of Blinman. He took an active role in the management of these two iconic sheep stations, but over time, formed the view he was better off concentrating on his medical career.

After graduating, Bob undertook a three-year stint working and training in London under the tutelage of two of the world's leading surgeons.

On his return, he set up his own surgical practice alongside his father in the Liberal Club building on North Tce. Shortly after that, he met Melbourne beauty Lucille Jost, a physiotherapist, who he went on to marry.

Bob was renowned for being good in a crisis – the combination of a cool head, intellect and a positive demeanour meant he was particularly adept at dealing with difficult situations – a handy trait in the operating theatre or hospital ward.

He went on to have an illustrious medical career including being Head of Unit at the RAH, for many years, and being a pioneer in the use of laparoscopic (keyhole) surgery in South Australia.

Many trainee and younger surgeons sought his counsel and he was generous with his time for people he could see were committed, but who might benefit from some assistance or guidance.

He often said to his children that 'from those to whom much is given, much is expected'. This approach was a central tenet of his Christian values. He knew that most people had not been dealt the hand he had, so beyond his commitment to and support of Lucille and his children – Mark, Tony, Christine and Peter – he gave much of his time – with the support of Lucille – to St John Ambulance, the Knights of Malta, Meals on Wheels, the local church, the RAH – wherever he thought his capabilities could have a positive impact.

Bob was a keen sailor, despite suffering from seasickness, and would throw himself wholeheartedly into studying sailing tactics and strategies in the evening after work. He sailed for many years and enjoyed some success.

Another favourite pastime was camping with the family in the Flinders Ranges, and he also loved tennis – in particular playing with friends on a good grass court, including his own!

Through his talents, his quiet strength, decency and respect for the people around him, Bob contributed much and brought the best out in people.

During the months preceding his death, Bob continued to be cared for by Lucille. His final sentence was 'I love you', to Lucille.

This obituary was taken from the eulogies delivered by Bob's sons Tony, Mark and Peter. The AMA(SA) extends its condolences to Bob's family and friends.

SOUTH AUSTRALIA'S GRAND FATHER OF GERIATRIC MEDICINE

A tribute to Peter Last.

BY DR LU MYKYTA

Peter Last was a truly great man. The Order of Australia Medal is but faint praise and does not get close to honouring him in a manner commensurate with his achievements.

I believe that he can rightly be called the Father of Geriatric Medicine in South Australia, just as Dr Marjorie Warren was named the Mother of British Geriatric Medicine for her work in in the late 1930s.

Let me state my case. Under Peter's leadership the RGH (Daw Park) became an elite geriatric hospital. We should remember that at that time most of the patients were World War I veterans and war widows, with the occasional Boer war veteran thrown in.

It was innovative and exciting. Best practice was the least that was acceptable to Peter. In many ways it was a better general hospital than the Royal Adelaide.

Peter introduced and enforced the bio/psycho/social model long before it became known by that name. This holistic approach is the only way that chronic illness must be understood and managed, particularly something as complex as dementia. Anything short of that is simply bad practice.

In 1966, I considered myself fortunate to clinch a second-year job at the Repat. Peter's reputation made it the best and most sought-after second year job in South Australia. I returned as Peter's Registrar in 1969. I have always said that Peter was my mentor and role model. I am glad that he heard me saying that in later years.

He was also mentor and role model for the late Michael Burr, who had been Peter's registrar before taking up the post of specialist in rehabilitation at RGH. I returned to Australia from England where I qualified as a geriatrician when Michael moved to the RAH. Like Michael before me, I openly advocated the cause of geriatric medicine locally, then as the national consultant in rehabilitation for the Repatriation Department (we both considered that rehabilitation was a key element of geriatric methodology). My successor was Philip Henschke, who I know also considers Peter as his mentor and role model. Philip was the first of us to practice and preach the message of geriatric medicine openly.

The three of us presented the case for the specialty of geriatric medicine at a national RACP Conference Plenary Session with Peter as the convener.

I say this in all seriousness and with no fear of contradiction.

REDUCING CONGENITAL CYTOMEGALOVIRUS INFECTION

New guidelines have been released for the prevention of congenital CMV infection (cCMV).1

The new guidelines for the prevention of cCMV1 were published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

The Australian Government Department of Health also released the 2019 Edition of Clinical Practice Guidelines, Pregnancy Care earlier this year which includes a comprehensive section on preventing cCMV.2

Based on international epidemiology, approximately 400 children are estimated to be born each year in Australia who will have or will develop cCMV-related disease from primary and non-primary maternal infection.3 Clinical presentations of cCMV can vary greatly from being entirely asymptomatic to causing severe neurological impairment and even fetal death. Importantly, cCMV is the most common non-genetic cause of congenital sensorineural hearing impairment and unlike most other forms of congenital hearing impairment, hearing can deteriorate over time.

CMV is often excreted by children under the age of two years, particularly by those who attend day-care facilities, and can be transmitted through their saliva, nasal secretions, urine and faeces. CMV is a relatively common infection with the seroprevalence rates in Australia ranging from 38% for children aged 1 to 2 years rising with age to 50% in 20 to 24-year-olds to 79% in 50 to 59-year-olds.4

Recent studies provide evidence that informing pregnant women about how to reduce exposure to CMV during their pregnancy can reduce the incidence of cCMV infection. In March 2019 the RANZCOG published new guidelines aimed at reducing the transmission of CMV through saliva, urine and nasal secretions from the high risk group of toddlers to expecting mothers.3 The guidelines are intended for (i) all health professionals responsible for providing maternity care, (ii) pregnant women and (iii) the general community.

The RANZCOG guidelines are comprehensive and include 10 specific recommendations, covering the following topics; transmission of CMV; serological testing for CMV; diagnosis of primary CMV infection; diagnosis of fetal infection; management of suspected or proven congenital CMV infection and; neonatal investigation and management.

In brief, recommendations 1-3 make it clear that all women trying to conceive or who are pregnant should receive information about CMV prevention regardless of their CMV serostatus as part of routine antenatal or pre-pregnancy practice. The five key hygiene messages are:

- Do not share food, drinks, or utensils used by young children (less than 3 years of age)
- Do not put a child's dummy in your mouth
- Avoid contact with saliva when kissing a child
- Attention to hand hygiene, when changing nappies or when in contact with urine. Thoroughly wash hands with soap and water for 15–20 seconds, especially after changing nappies/, feeding a young child, or wiping a young child's nose or saliva
- Clean toys, countertops, and other surfaces that come into contact with children's urine or saliva, and not sharing a toothbrush with a young child

The provision of this prevention information to women and their families is strongly supported by cCMV consumer groups, with the recognition that the level of awareness about cCMV in maternity care providers and in pregnant women in Australia is relatively low.

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HYUNDAI i30N: FASTBACK

While sticking with Hyundai, whose all electric ecologically and politically correct Kona was featured in our last edition, motoring duo Rob Menz and Phil Harding decided it was time for a bit of fun with the high-performance version of the i30, in Fastback mode.

Phil: Well, I picked the car up and let me say straightaway that it's a corker. Something that's certain is that N does not stand for normal – one version I've heard is that Hyundai borrowed some engineering expertise from BMW relating to their M vehicles and that this is just the next letter in the alphabet. I've driven the regular i30 several times as a rental vehicle, and while I have always thought it to be a good car, this N version is something else. It's perfectly tractable while driving around your suburb or pretending to be a shopping trolley, but select 'Sport' in drive mode and hit the N button – just two of the myriad of controls on the steering wheel – and things really start happening. I'll let you talk about that!

The Fastback model we tested is a very attractive-looking vehicle with its low sloping back roofline, which incidentally does not seem to compromise rear-seat headroom excessively. Bright red pinstriping and brake calipers make a special statement, underlined by the 19-inch mags shod with 235/35 rubber. Inside, the instrumentation and controls are comprehensive but neatly laid out with all the electronic gadgetry you'd expect, including satnav and phone connectivity, although as with some other cars if you want to use Apple carplay or the Android equivalent you need to connect your phone with a cable which some people might find a nuisance. The sports seats were very comfortable with a lot of lateral support for all that twisty driving I'm sure you will have enjoyed: not heated or cooled in our test car, although I suspect that sort of thing might come with some higher spec options. The 6-speed manual gearshift was very clickety-click and short throw, reminiscent of my MX5 when it was new. Cruise control functions are integrated into the steering wheel, but not of the adaptive type and not capable of controlling downhill speed given the manual transmission. So, let's have your usual history roundup and an account of the driving experience ...

Rob: As you say, we seem to have gone from the sublime to the ridiculous again.

Hyundai's i30 hatch won a car of the year following its release in 2007. Since then it has continued to impress as a well-credentialed hatchback, now in its third generation, picking up a slew of awards since then. Hyundai in their wisdom and no doubt responding to consumer feedback last year developed a hot hatch (i30N) and this year released what they call a Fastback version, which is the car we have been testing.

Rather than simply bolting a turbo to their existing 2 L petrol engine, Hyundai spent a lot of time developing the suspension, dampers, brakes and even some custom-made Pirelli P-Zero HN tyres. Some of this testing took place at Nürburgring and I have heard that is why this is the 'N' version (another version relates to Hyundai's Global R&D Centre in Namyang, Korea). The Fastback is in reality a cross between sedan and hatchback, with the boot incorporating the back window and there is a striking resemblance to the Mercedes CLA. And, as you say Phil, the N is a delightful car to drive.

... There are also G force sensors such that if you enter a corner a little fast on a country road, the cruise control slows the car ...

Driving modes include eco, normal and sport, and then there is the customizable N function which is said to give over 1900 different combinations. One week of testing did not allow all of these to be checked. The performance is quite remarkable with a claimed 0-100 km/h in 6.1 seconds. The electronically limited top speed is 250 km/h. Needless to say I stayed well short of the top speed although a speedo reading up to 300 km an hour was impressive.

While we are talking numbers 202 kW and 378 Nm are extraordinary for a 2 L four-cylinder engine.

Like you Phil, I found driving the N gently around the suburbs in comfort mode gives little clue to the extraordinary performance available in sport mode. The power is available at relatively low revs and feels seamless unlike some other turbo cars which have a significant change in character at about 3-4000 rpm.

Even if you are feeling too lazy to change down gear, there is sufficient torque at 90 km/h to allow safe overtaking. However, in modes other than eco, there is a rev matching option which ensures very smooth down changes accompanied by a delightful exhaust 'blip'. The N is only available in 6-speed manual, although an 8-speed auto could be available in the near future.

Whilst I did have a short and extremely pleasurable squirt through the Hills, most of my driving was on the freeway with work trips to both Riverland and Yorke Peninsula. The Riverland trip required an overnight stay, and keen to try different accommodation from the country club or pub, we spent the night aboard the River Murray Queen, which is moored permanently as a hotel at Renmark. And a return trip to the Riverland is never complete without a small cleansing ale on the balcony of the Swan Reach Hotel, overlooking the pelicans, the red gums and watching the ferry.

The Fastback retails at $41,999 in the standard version that we tested. However, even the 'basic' version is brewing with safety and infotainment features such as Lane Keeping Assist, which actually keeps the car out within a lane, although if you try to drive hands-free, a notice appears on the dash reminding you to keep your hand on the wheel; Hill Start Assist – which stops the car rolling back when the clutch isn't engaged; rack-mounted Motor Driven Power Steering; and if feeling competitive, launch control. There is even a Driver Attention Warning, where a reminder to take a break is accompanied by a dashboard image of a steaming cappuccino!

There are two option packs available – one called 'luxury' and one called 'luxury with sunroof' at $3000 and $5000 respectively. The luxury pack includes niceties such as rain-sensing wipers; heated, power front seats; keyless entry; and wireless phone charging. The five-year warranty includes non-competitive track work and fitting of semi-slick tyres.

Are there any downsides? The N has a large turning circle, although once noted, this does not present too much of an impediment. The other thing that takes getting used to is the very small view out the rear window. Will I buy one? Given that some of the people who occasionally use my car are not used to manuals, I will probably wait until the automatic version is available.

However the N does represent great value for money and if you are interested in a small performance sedan it should be close to the top of your list.

Test car made available through Hyundai Australia.

Dr Robert Menz is an enthusiastic motorist who will probably be in the market for new car soon. Dr Phil Harding likewise but probably later.

... Driving the eKona is very much like driving any other small luxury car, with a couple of notable exceptions. The driving position is very comfortable, with an electric multiadjusable front seat and adjustable steering wheel ...

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NEVER TOO SOON TO PLAN FOR RETIREMENT

For some doctors who have been in their professions for decades, stepping away can highlight a loss of identity, particularly if they have neglected to balance years of responsibility to their patients and their practice, with fulfilling home lives and hobbies.

It can also put the focus on ongoing financial commitments.

If a medical professional hasn't planned for retirement, tucking money away into superannuation funds and asset portfolios, the financial stress can be a barrier. Financial security can have an enormous influence on retirement decisions, and many doctors extend their careers for this reason.

Retirement is about earning passive income from investments, so it all begins with creating that wealth – and turning human capital and your earning ability into financial capital.

"Medical professionals need to obtain financial advice and develop a financial plan from early in their careers, particularly if they are self-employed," says Hood Sweeney's director of Financial Planning, Adrian Zoppa.

HOW MUCH IS ENOUGH?

The first things to figure out – ideally when you are a decade or more away from even contemplating retirement – are as follows:

- How much retirement income is feasible
- How best to spread spending power over retirement
- How to allocate capital among various investments differing in amount of control and guarantees provided
- How to choose an asset strategy that allows for systematic portfolio withdrawals (pension payments).

Both the medical practitioner and financial adviser must consider how best to combine income tools to meet a broad set of goals and manage risks that jeopardise those goals.

SUPERANNUATION

Superannuation is a key part of retirement planning, and should commence well ahead of contemplating retirement. It's also is a tax effective way to build wealth.

The types of superannuation funds vary. Accumulation funds accumulate contributions and earnings to provide a final retirement benefit, they are dependent on contributions made and earning rate of the fund. Defined benefit funds are determined by factors such as age, final salary at retirement, and years of service with employer, and are not typically reliant on investment returns; they are also generally guaranteed by the fund.

Retirement Planning Can Be Challenging For Medical Professionals On Both An Emotional And Financial Front.

During the past decade or so, there has been a surge in the number of self-managed super funds (SMSF) being established and many dentists and doctors have followed that trend. A SMSF gives medical practitioners control and flexibility with their investment strategy.

"it is important to seek professional advice before setting up a SMSF," says Adrian, "as administrative requirements are onerous and managing a SMSF can be time consuming.

"Also, on the tricky side, the legislation around superannuation is constantly changing, with government regularly enforcing major, and often complex reforms, which can impact your contributions. It's important to work with someone who can keep you abreast of changes," he continues.

"On the positive side, the control aspect of SMSFs allows for direct investment choices, tax and estate planning, and consolidation as up to four members can combine member benefits into a single strategy for scale benefits and efficiency of management."

RISKS OF RETIREMENT

The risks of retirement – or the ability to live off investment income – must be considered as you make investment plans – for example: outliving your assets; volatility in the stock and interest rate markets; rising inflation driving up cost of living; involuntary job loss or inability to find part-time work; divorce, separation or death of spouse.

The challenge, or goal, is to achieve consistent income for life, maintain control over your assets, hold reserves for unexpected expenses, build an estate and optimally, avoid spending cuts and running out of wealth.

Superannuation pensions, investment portfolios, managed funds and rental income are all income tools that can help retirement wealth planning. Adrian says, "It's imperative to focus on the 'actual' income generated from your assets (not the projected income and potential growth) and take inflation into account."

If retirement is on your horizon, now is the time to act.

Hood Sweeney is the AMA(SA)'s preferred provider for financial services. If you want to know more about planning for retirement, please contact one of the Hood Sweeney Health team on 1300 764 200.

INFECTED BLOOD PRODUCTS: AUSTRALIA'S GREATEST MEDICAL DISASTER

RICHARD DAVIS
MBBS, FFARACS, FANZA, CF

REVIEW BY
PROF BRENDON KEARNEY

This small book raises many significant and important national interest issues. It is based on work done by, and is written by, Richard Davis, an anaesthetist, who has devoted his life to the safety of blood and blood products. In the 1970s he introduced pre-donated autologous blood transfusions in South Australia. He believed autologous blood to be safer and better than the then-standard Red Cross homologous blood. He also writes from the heart, as a close friend had died from IDV due to a contaminated blood transfusion.

Richard Davis was awarded a Churchill Fellowship to study blood transfusion medicine in Europe and America. In 1980, the Royal Australasian College of Anaesthetists and Intensive Care, awarded him the Gilbert Brown Prize for research into safe blood transfusions.

Davis argues in his book that Australia was slower than other nations to respond to the issue of tainted blood. He believes that proportionally more Australians were affected than in many other countries. He also believes there were conflicts of interest involving the Federal Government and CSL and the Red Cross which have still not been resolved.

The Australian Red Cross believes that about 8,000 Australians were affected with Hepatitis C and about 2,500 were infected with IDV after being treated with contaminated blood and blood products. Australia's Tainted Blood Action Group believes up to 20,000 Australians were infected. Other nations have conducted national inquiries, all of which have found the disaster was entirely predictable and was their worst medical disaster. Developed nations have introduced arrangements to ensure that blood and blood products are now controlled by appropriate governance and organisations.

In Canada, after prolonged legal battles, the Supreme Court found the Canadian Red Cross guilty of mismanaging the nation's blood supply. In France, the Health Minister and blood transfusion doctors were convicted of failing to adequately screen blood, leading to the deaths of people from AIDS. In Ireland, a tribunal was established to review the issue. In Germany, the German Red Cross, the German medical profession and the Government were blamed for selling contaminated blood. In Italy, a Court ordered the Health Ministry to pay damages to people infected. In the USA, following Court action, haemophiliacs who were infected by contaminated blood products received a settlement of $100,000 each, plus legal fees. In Switzerland, where the Red Cross is revered, people were shocked when it was found the organisation had been selling infected blood.

England is presently conducting a major national enquiry and Davis believes that a similar review should occur in Australia. It is estimated that nearly one-third of infected haemophiliacs in Australia died from the effects of IDV. Davis questions why the Government allowed the importation of foreign plasma, much of which proved to be contaminated. He also questions why the Australian Red Cross collected blood from prisoners, knowing that they were frequently infected with blood-borne viruses. He also asks why safer, heat-treated, blood products were not released for use until the old, mi-heat-treated, but contaminated, stocks had been used. He infers that the Federal Government, CSL, and the Red Cross (which had provided valuable blood services but had benefitted financially from government payments) acted to preserve their interests while not acting quickly to preserve the health of people receiving blood products.

Haemophiliacs are a small group within the Australian community. They have suffered enormously from contaminated blood products. Although the blood system in Australia is now safer, the incentives for reimbursement and provision of services have not changed fundamentally. Fortunately, doctors are now much more careful when using blood products.

The haemophiliac population is such a small, vulnerable group that they are unable to instigate a review. However, at the very least, the Government should fast track the provision of gene therapy services for haemophiliacs in order to avoid future problems with contaminated blood products.

For anyone wishing to read Dr Davis' book, a limited number of copies are available (and can be obtained by telephoning him on 0437 838 827. Also, the author advises that a revised and expanded version of the book is currently in preparation with publication anticipated later this year.

NOTICES

DR CHRISTOPHER BROWN and DR NANCY CULLEN wish to advise that their private practice at 3/79 Pennington Terrace, North Adelaide, closed on 30 June 2019. Nancy and Chris would like to thank all those who have supported them and the practice over the many years.

DR KYM DIAMANTIS, **ear, nose and throat surgeon**, wishes to advise referring general practitioners and colleagues that he will be relocating his southern suburbs rooms from May 2019 to Blackwood Hospital. His new visiting rooms will be at **Specialist Clinics at Blackwood Hospital**, 13 Laffers Road, Belair. Dr Diamantis will also continue to visit Victor Harbor and his main rooms are Parkwynd ENT, 137 East Terrace, Adelaide. Referrals may be forwarded to our city location, phone 8223 2633 or fax 8223 3811. Our website is www.diamantisent.com.au and email is maddy@diamantisent.com.au.

DR ANDREW MOEY wishes to announce that he is consulting in general neurology at Wakefield Clinic, Level 1, 270 Wakefield St, Adelaide SA 5000 Ph: 83592411 Fax: 83592477. His subspecialty interests are in stroke, headache medicine and botulinum toxin treatment for neurological indications. He continues as a staff specialist at the Neurology Department, Lyell McEwin Hospital, Haydown Rd, Elizabeth Vale, Adelaide SA 5112.

RICHARD HAMILTON MBBS, FRACS, plastic surgeon, wishes to notify colleagues that his private clinic Hamilton House Plastic Surgery has recently been fully accredited under the Australian National Standards (NSQHS) for health care facilities and remains fully accredited by the American Association for the Accreditation of Ambulatory Surgical Facilities International (AAAASFI).

Richard Hamilton continues to practise Plastic and Reconstructive surgery at Hamilton House, 470 Goodwood Road Cumberland Park with special interests in skin cancer and hand surgery. Excellent 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. 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. See www.hamiltonhouse.com.au.

ROOMS FOR SALE OR LEASE

BLACKWOOD/BELAIR

Professional consulting rooms available on a sessional or permanent basis. Located in Belair on the site of the old Blackwood Hospital, these newly renovated consulting rooms also offer minor procedure and treatment rooms. Free on-site car parking. Radiology, pharmacy and blood collection services also provided on site. Administration services available by negotiation. Contact Karen on 8472 3232 for more information.

STIRLING

Several recently renovated consulting rooms available for lease on flexible fixed term or sessional basis within a group of allied professionals located near the Stirling Hospital. Ample free parking and a range of services provided on-site and also within close proximity. Administration support can be arranged. Contact John McQue for further information on 8370 9777.

POSITIONS VACANT

FULLTIME OR PART-TIME VR GP REQUIRED, GAWLER

We are a privately owned, family friendly, fully computerised and mixed billing practice. Our aim is to provide holistic health care. In addition, we have a proactive approach to preventative health, involving out practice nurses. Gawler offers a great blend of town and country. Contact 8522 1844 or jsalagaras@gawlermedical.com.

NOTICEBOARD

MEDICAL BENEVOLENT

The Medical Benevolent Association of SA can provide financial assistance to medical practitioners in need and their loved ones. To contact the MBASA contact the AMA(SA) office on 8361 0107.

PRACTICE RESOURCES

The AMA has a range of practice support tools for our members to access. To find out further information about our resources please contact the AMA(SA) on 08 8361 0108 or www.ama.com.au

HAVE YOU GOT SOMETHING TO SAY?

Have you got information to advise about your practice details, rooms for sale or lease, or a vacant position to fill? Book a classified advertisement in medicSA's practice notes section.

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To find out more or to make an article suggestion, call Heather on 0409 196401 or email heather@ zestcommunications.com.au. You can also write to the Managing Editor c/o of the AMA(SA), PO Box 134, North Adelaide SA 5006

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Membership of the AMA(SA) is open to medical practitioners who are registered to practise medicine in South Australia.

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- Norman Waterhouse (Legal)
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