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Long distance

Virus after-effects loom as a game changer

RURAL DOCTORS NEGOTIATIONS CONTINUE • OUR NEW AMA FELLOW
WCH PLANS - NO ROOM FOR GROWTH • EXPERTS QUESTION RTWSA GUIDELINES
REDESIGNING HEALTH SYSTEMS FOR ALL-ROUND BENEFIT • VALE

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They're all smiles for *Stock Journa*l journalist Claire Thomas's camera, but AMA(SA) President Dr Atchison and Rural Doctors Association of SA President Dr Peter Rischbieth have not found much to smile about the crisis over rural doctors' contracts in recent months. For a summary of the ongoing negotiations with SA Health's Rural Support Service, see page 7.

President's report

Dr Michelle Atchison

> ***... and we will continue to advocate for members and patients so we all are in the best place to manage the virus and its impacts ...***

The first 100 days, did I sink or swim?

They say that what you achieve in the first 100 days in a new job is crucial to your long-term success – that your progress at this point is an indicator of your readiness to act. These first 100 days in the AMA(SA) presidency have been a steep learning curve that being Vice President could not have prepared me for. I have held other leadership positions, such as South Australia's psychiatry chair for six years, but the AMA covers such a broad area in medicine that it is difficult to prepare for this huge leap from the 'second rung' to the top. The buck really does stop here.

When I started this position, it helped that I sat down with the 'executive team' – Samantha Mead, Claudia Baccanello and Karen Phillips – along with the rest of the great AMA(SA) team, to discuss priority areas, to explore how I would work with the rest of our great Council, and to talk about how I would juggle my private practice commitments and the many demands on my time that come with this role. I warned former Presidents Dr Chris Moy and Associate Professor William Tam, and colleagues in other roles, that I would be calling on them for guidance and assistance, and I thank each of them for their unfailing support.

Priority tasks have included developing relationships with partners and colleagues, supporting the work to finalise rural doctors' contracts, getting my head around the Women's and Children's Hospital plans, and surviving my first State Budget lock-up as President. I have met with organisations from MIGA to Ahpra to ReturntoWorkSA (RTWSA). A recent update with Dr Roger Sexton about the work of Doctors' Health SA has helped me understand how funding does not match the need for this important organisation. Meeting with medical student representatives from the University of Adelaide alerted me to issues relating to the future of our profession and the AMA, including the transition to an MD program there. All of these meetings have helped me build context for the work we do through the AMA in South Australia.

Building positive relationships with outside agencies is crucial, but just as important is fostering strong, mutually beneficial relationships within the AMA(SA). I have thoroughly enjoyed getting to know the staff and Council members on a different level now as President. Being available for members who are experiencing difficulties in their workplaces builds on the culture and bullying work from 2020 that is close to my heart. And while sometimes challenging, it is immensely gratifying to be able to help members through the many concerns they bring to us, in the belief that the AMA is the best source of guidance and advice for them and their patients. The many requests for submissions relating to health initiatives such as the Draft 'South Australian Tobacco Strategy 2021-2026, the RTWSA draft Impairment Assessment Guidelines and the Suicide Prevention Bill also demonstrate how the AMA's input is valued and appreciated.

And then there is COVID. Having assumed the presidency in the middle of the pandemic, it is impossible to know what this role would be like without it, but I am sure it has added multiple layers to my workload, as it has to the work of every one of our members. Every change in vaccine guidelines and to health care restrictions brings questions from members and the public. Just like everyone else, we medical 'experts' have been perplexed and frustrated by decisions in this state and in other jurisdictions, and at the national level. We have been annoyed when delays in vaccination are attributed to individuals, when often they are doing what they can to follow the rules and minimise the spread of infection, yet still cannot access the vaccines so important to Australia's response to COVID. Still, our good relationship with SA Health helps have some of the queries answered and obstacles removed. We will continue to advocate for members and patients so we all are in the best place to manage the virus and its impacts – hopefully before an outbreak puts South Australians at risk, both our members, the public and the media.

So, what for the next 100 days? Along with the continuing fight against COVID, the clear priorities are to finalise the rural doctors' contracts, maintain pressure so there is significant and meaningful clinical input into nWCH planning, and to develop strategies for emergency department block to help the whole health system. I look forward to leading the charge, and hope I can count on you all to stand with me.

From the medical editor

Dr Roger Sexton

Trust me, I'm a doctor.

I have been pondering the word 'trust' lately, and recalled a conversation I had with an educated group of Americans in Boston when I was studying there briefly five years ago.

Donald Trump had been in office for one year and I remarked to the others present that he was probably the most famous person in the world at that time. We discussed his corrosive use of the term 'fake news' and I then asked them who they trusted in American society.

All of them were clearly troubled by this enquiry and I was almost embarrassed to see them struggle to answer. It made me wonder what sort of a list we would devise here in Australia, in response to the same question.

Consider who or what you would place on such a list. Would it be an individual, a group of people, a brand, a device or an organisation at the top of your list?

We have high expectations that our sporting heroes will be honest, virtuous, moral, inclusive and national role models especially for younger people.

Supermarkets and hardware megastores top the list of most trusted brands in Australia.

Our most trusted charity is the Royal Flying Doctor Service.

Among the top four most trusted people in Australia are three doctors: Fiona Stanley and Ian Frazer.

Health professionals dominate lists of the most trusted occupations in Australia with doctors, nurses and paramedics sharing the top spots while politicians often make up the rear.

The trust held by people in many things has eroded over time – think whether you completely trust a photograph to truly represent an image.

This trend is disturbing and leaves people searching for 'a firm belief in the reliability, truth, ability and strength of someone or something'.

Over the past 18 months Australians have recognised the value of the knowledge, skill and judgement that doctors have brought to the leadership of the pandemic response.

Politicians have recognised this and have at every opportunity gladly shared the podium with doctors. They repeat time and again how they have always taken doctors' advice. Does the phrase 'If pain persists, see your doctor' ring a bell?

So, Australians have had to resolve the fact that their 'most and least trusted' are standing together promulgating the same message. What and who does the public believe?

People may choose to resolve this by increasing their trust in politicians or alternatively reducing their trust in doctors. To avoid the latter, doctors must remain independent partners in the pandemic response and a strong advocate for the role of the profession and, first and foremost, the health of the public.

Welcome to the AMA.

Dr John Williams

Declining rural system 'catastrophic' for care

AMA(SA) is urging the State Government to invest in rural doctors and hospitals to support the future of regional communities.

AMA(SA) has been at the centre of negotiations to introduce better working conditions for South Australia's rural doctors.

During negotiations with SA Health's Rural Support Service (RSS), during the largest gathering of the state's rural doctors in history, and in meetings with Health and Wellbeing Minister Stephen Wade, AMA(SA) has urged SA Health to recognise how the plight of rural doctors is having a devastating effect on the health and safety of South Australians across the state.

AMA(SA) Vice President and Port Lincoln GP Dr John Williams says AMA(SA) has worked with Rural Doctors Association of South Australia (RDASA) President Dr Peter Rischbieth and other doctors to develop a package of conditions to help doctors and hospitals care for their patients and communities.

They are seeking conditions that reflect the high workload rural GPs experience and the regular out-of-hours care they provide their patients and communities through regional hospitals, in addition to their general practice commitments.

Dr Williams says the offer AMA(SA) and the RDASA put to RSS in March was designed by rural GPs 'to acknowledge our work, inject new life into the shrinking rural GP workforce and support country communities through their rural hospitals'.

'Complete despair'

In July, AMA(SA) and RDASA received from RSS a response that led to what Dr Williams described as 'complete despair and frustration' among rural doctors.

The previous contract expired on 30 November 2020, and an extension was in place until 31 May.

In 2021, a number of regional hospitals, including Maitland and Minlaton, have been unable to staff emergency departments at critical times – including over the June long weekend and Easter – leaving senior nurses to run the ED with the help of telehealth services and a paramedic. The GP Clinic at Peterborough has closed because it cannot staff the practice.

AMA(SA) and the RDASA say the cost of their proposed package would represent half to two-thirds the current cost of running the Port Lincoln emergency department solely with locums.

Dr Williams says that while the government has moved to implement a rural generalist pathway with additional training and recognition of the scope of rural practice, there are few financial incentives for junior doctors to choose the 24/7 life of a country GP.

'Professionally, the life of a country GP with access to a rural hospital is very rewarding but it can be tough – especially given the workload and the lack of opportunity for professional development. Even obtaining locum support to take a holiday can be a challenge,' Dr Williams says.

The associations are urging doctors, health colleagues and rural residents to speak out about the conditions in their areas and to contact their local members of parliament.

State of play

At an online meeting on 21 July, doctors from across the state assembled to discuss the negotiations and next steps.

Dr Williams and RDASA President Dr Peter Rischbieth led a meeting of nearly 100 doctors – the biggest group of rural doctors at such a meeting in the state's history.

Dr Williams opened the meeting with an outline of the AMA(SA)/RDASA position.

'Following six months of little progress in negotiations, on 12 March 2021, the RSS was asked to consider a joint submission from AMA/RDASA to overhaul and modernise the 'fee for service' contract,' Dr Williams told the group.

'The intent of the proposal is to recognise the changed reality of rural practice and to support our current and future doctors to practise, and stay, in rural South Australia.

'The RSS failed to honour both their commitments to move away from the current piecemeal 'fee for service' arrangements and to meaningfully consider the submission.

'The objective of the AMA/RDASA proposal is reforming a system that is not working. To encourage new and existing doctors to come to and remain in the country. To support experienced doctors to teach and mentor the next generation. To recognise that the skilled health care professionals in rural South Australia are more than contractors providing piecemeal consultations. Our proposal is about providing solutions.'

Doctors at the meeting were told the issues not addressed by SA Health included:

- no incentives or supports to encourage new professionals to work in rural SA
- no support for teaching the next generation of rural doctors
- no meaningful support for rural doctors to become involved in quality improvement
- the ongoing, self-destructive system that pays locums a premium to fill short-term vacancies rather than encouraging the local workforce, which undermines the motivation or incentive to live and work in the country
- failure to address the onerous administrative burden (for all parties) of detailed FFS billing, rather than simplifying to a system of realistic hourly or sessional rates
- continuing to disadvantage rural patients in smaller centres by
- refusing to pay doctors for hospital attendance for motor vehicle accidents, outpatient presentations, chemotherapy, and rape and other assaults.

'AMA(SA) and the RDASA are keen to work with the RSS to develop a mutually beneficial and forward-looking contract to provide solutions,' Dr Williams says. 'More of the same simply means a continuation of the problems undermining rural health.'

Local factors key to long COVID study

South Australian researchers have been in a unique position to study another, perhaps long-lasting, fall-out of the pandemic – the after-effects of COVID-19 or 'long COVID'.

Professor David Lynn

The small number of people in South Australia infected with COVID-19 and reporting lingering after-effects has created a unique opportunity for the study of what's become known as 'long COVID'.

South Australian Health and Medical Research Institute (SAHMRI) immunologist Professor David Lynn says that while the small number of cases limited the size of the study in South Australia, there were distinct advantages to researching those cases.

'Because community infection was so well contained, there was a relatively low risk of people being re-exposed,' he says. 'In addition, the slow roll-out of vaccines meant few people were vaccinated – reinfection or vaccination would make it harder to identify the effects of previous SARS-CoV-2 infection.

'The situation was very different to the US and UK, where people were constantly exposed and started being vaccinated quite early.'

The collaboration between Prof Lynn's team at SAHMRI and colleagues at the University of Adelaide, Flinders University, the Women's and Children's Hospital, and the Royal Adelaide Hospital has delivered crucial insight into the lasting immune system dysregulation caused by COVID-19.

Their study has shown that people's immune systems were significantly altered six months after their COVID-19 infection. Prof Lynn says immune cells and gene expression experienced during this post-infection period hold clues to the intriguing 'long COVID' symptoms affecting some patients.

Professor David Lynn arrived at SAMHRI and Flinders University from Ireland in 2014. He says his interest in long COVID comes from work going back more than 10 years, when he found some individuals in Vietnam infected with typhoid had significant effects of the infection more than one year later.

When reports of long COVID started to come from the UK, US and elsewhere, Prof Lynn wondered if the reported symptoms were related to a similar ongoing impact. With colleagues Professor Simon Barry and Dr Branka Grubor-Bauk of the University of Adelaide and their teams, Prof Lynn and his systems immunology group examined the impacts of the disease on the immune system for up to six months post-infection.

Their study involved an in-depth assessment of a South Australian patient cohort, termed 'COVID-19 SA', set up by Dr Grubor-Bauk, Professor Beard and Professor Barry, in collaboration with A/Prof David Shaw and Dr Benjamin Reddi from the Royal Adelaide Hospital.

The immune systems of 69 participants between 20 and 80 years of age were examined over a six-month period following infection with the original strain of SARS-CoV-2. Of the total cohort, 47 were recovering from mild infection, six from moderate cases and 13 from severe COVID-19 disease.

'Substantial alteration' to immune system

The analysis examined antibody responses, the expression of thousands of genes in the blood, and approximately 130 different types of immune cells, via blood samples taken at 12, 16 and 24-weeks post infection. Responses were compared to healthy controls.

Prof Lynn said the results showed that the immune system of people previously infected with SARS-CoV-2 was significantly altered until at least six months post-infection.

'The study found substantial dysregulation of immune cell numbers that was strongest at 12-weeks post infection but was still evident in most cases for up to six months and potentially even longer," Prof Lynn says.

In addition to an increased number of immune cells and antibodies, there was strong dysregulation of gene expression, particularly in those genes linked to inflammation. Gene expression refers to information stored in DNA that regulates how cells respond to changing environments.

This can include controlling when and how much response is made against an invading virus.

Prof Barry says deep immunophenotyping will develop our understanding of how rare immune cells help repair the damage and set up immunity to COVID-19.

'By taking a deep dive into the immune cells in these patients, we've found some new players linked to the disease, and these may help understand why some people have more severe disease, or get long COVID,' he says.

The study didn't have the capacity to analyse the extent to which participants were experiencing the symptoms commonly associated with long COVID such as fatigue, shortness of breath, chest pain and brain fog. However, Prof Lynn says it's likely these symptoms are related to the upheaval of immune cells and gene expression.

'One could logically infer that this dysregulation is linked to the physical symptoms of long COVID, but more research is needed to prove this,' Prof Lynn says.

The reason some individuals are so harshly affected by long COVID, while others are barely affected, remains a mystery.

Already somewhat surprised at the level of symptoms being reported at six months, Prof Lynn is keen to examine what happens over the course of time.

'Evidence to date indicates that for most people there is a slow return to "normal" at about six months after infection,' he says. 'But some people seem to have persistent dysregulation of their immune systems.'

Some of the long-term changes to the immune system may be beneficial, he says, and may support B and T cell mediated immunity to the virus.

He has also been surprised to find that the level of immune dysregulation does not necessarily equate to severity of symptoms. Immune dysregulation was evident even in those patients who experienced mild infection.

'The data suggest that even with a mild infection, you may have long-term changes to the immune system lasting more than six months after infection,' he says. ''This suggests that even if you're not critically ill, you may have serious after-effects of COVID-19 – so you should do everything in your power to get vaccinated.

'We've seen a very broad spectrum in the rate of recovery and we still don't understand why some people are recovering so much quicker than others. The level of disease severity doesn't translate directly to the level of immune dysregulation and we haven't been able to find any patterns indicating that an individual's age or sex is a differentiating factor governing differences in recovery.

'Clearly there are other factors at play that need to be explored.'

The South Australian study has also added to evidence that those who've had COVID-19 become immune to the virus.

Participants' antibody titres indicated a high level of immunity for at least six months post-infection, but it's unknown whether the same result would be true for those who contract other strains.

'All patients involved in this study were infected with the original virus, so whether the same level of immunity and dysregulation would occur with variants such as Delta is unknown,' Prof Lynn says.

Subject to funding, the group plans to follow the individuals for up to three years post-infection and try and understand if there is evidence of 'very long lasting' impacts.

'At present there are no treatments for long COVID sufferers, and as the world slowly transitions to living with COVID, we will need to find answers and better solutions to prevent and treat long COVID in the years to come,' Dr Grubor-Bauk says.

Long road to recovery

The absence of knowledge about long COVID is frustrating both patients and doctors.

Dr Don Cameron

When Dr Don Cameron's patient of many years – a fit, healthy, hardworking baker in his 40s contracted COVID-19 from a Ruby Princess passenger during a flight home from a Sydney holiday, the patient considered himself relatively lucky.

His wife and daughters who were on the same plane did not contract the disease.

And while the disease was no fun, he wasn't as debilitated as others and after a couple of weeks of fever, dry cough and respiratory symptoms, it seemed to be over.

Then he began to become more and more fatigued. It became almost impossible to get up in the morning and felt like he was made of lead.

'There wasn't a lot to find on examination or his bloods,' says Dr Cameron, a GP in metropolitan Adelaide.

'Nothing jumped out at you to say he was suffering. Here was this young, fit bloke used to getting up at 4am and now he just couldn't do it. He has been poleaxed.'

Almost 18 months later, the patient is still suffering from what Dr Cameron firmly believes is long COVID.

'He was a strapping bloke with no underlying health conditions – fit and healthy – and here he was having trouble getting out of bed and he has been barely able to work,' Dr Cameron says.

'It is difficult to diagnose – if you follow the literature, this is one of the frustrations because these people are developing problems with long-term fatigue, respiratory problems, the foggy head that goes on and on, and there's no test we can look at.

'We can't look at inflammatory markers – he's got COVID antibodies as you would expect and he's subsequently tested and is antigen negative, so we are confident that he has actually recovered from the virus. But there's no test we can use.'

Dr Cameron says his patient's symptoms are consistent with the patterns identified overseas and captured in UK research literature.

'In the UK, they have a "Long COVID Register" and it seems that around one in three infected people develop long COVID,' Dr Cameron says. 'The literature also tells us that around 10 to 15 per cent of people are coming out of COVID with scarring to their cerebral blood vessels, scarring to their lungs, scarring to their heart muscle – when you are young you can deal with that, but when you get to 60 it becomes a problem.

'The frightening thing is that doesn't seem to be related to the severity of the illness.'

Study of the syndrome is in its early stages, with a South Australian collaboration one of the global efforts to investigate the increasingly worrying condition.

'We pride ourselves here at our practice on keeping abreast of the scientific and medical literature relating to COVID,' Dr Cameron says. 'There was not much treatment we could offer him and the only information that I could give him was that in the UK there was some data to suggest that getting vaccinated might help.

'In the UK, having these long COVID clinics provides validation and support for sufferers.

'There has been a huge frustration for people suffering from long COVID because obviously they feel the need to be validated - previously they were highly functioning and now they are struggling to get up the stairs at home.'

With his patient's Pfizer vaccination completed, Dr Cameron says the situation is hopeful.

'We have our fingers crossed for him,' he says. 'As I say to my patients, this time last year we were saying "vaccine, what vaccine?", and now we have these vaccines and they are fantastic.'

A global response

As the number of cases of long COVID escalates, researchers from around the world are rapidly building evidence of its symptoms and causes.

When people who had contracted COVID-19 started to report a range of ongoing problems long after the acute respiratory infection had subsided, many doctors believed the symptoms were associated with intensive care or lung function impairment.

Britain's National Health Service (NHS) reports that symptoms include extreme fatigue, shortness of breath, chest pain or tightness, problems with memory and concentration ('brain fog'), difficulty sleeping (insomnia), heart palpitations, dizziness, pins and needles, joint pain, depression and anxiety, tinnitus, earaches, nausea, diarrhoea, abdominal pain, loss of appetite, a high temperature, cough, headaches, sore throat, changes to sense of smell or taste, and rashes.

The UK Office of National Statistics has followed more than 20,000 people who have tested positive since April 2020 and found that 13.7 per cent reported such symptoms after at least 12 weeks post-infection. Researchers put the incidence of what was beginning to be called 'long COVID' at about 10 per cent. A Nature journal article (Marshall, 2021) said that if the UK prevalence was applicable elsewhere, more than 16 million people worldwide could be expected to have long COVID.

With increasing numbers of people reporting enduring these symptoms post-COVID, researchers have identified a 'long COVID syndrome'. Long COVID clinics have been established in the UK, the US and Europe to study and treat patients with enduring symptoms.

An international online survey (Davis, Assan et Al in the Lancet) of 3,762 individuals with suspected or confirmed COVID-19 illness suggest that long COVID is composed of heterogeneous sequelae (consequences of previous disease) that often affect multiple organ systems, which impact on functioning and ability to work. This study found 203 symptoms in 10 organ systems and traced 66 symptoms over seven months.

This is supported by a study by Norwegian researchers published in Nature Medicine (Blomberg et al, June 2021) which notes that COVID-19 is a complex systemic disease, affecting the cardiovascular, renal, hematologic, gastrointestinal and central nervous systems.

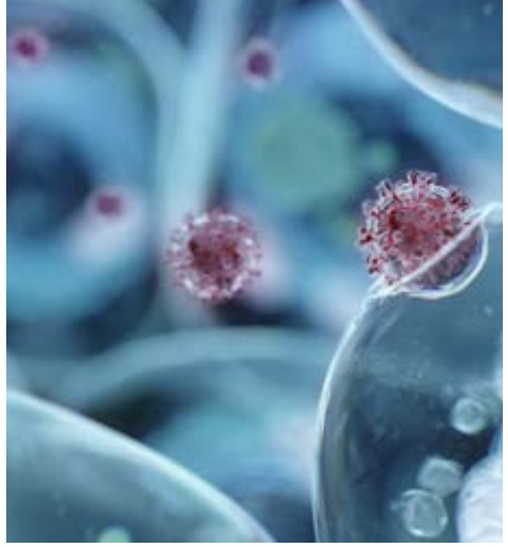
This study noted that patients with severe cases of COVID experienced lasting impairment of lung function related to fibrosis. The authors pointed out that before the pandemic, patient management in intensive care was frequently associated with mental and physical decline which could partially explain long COVID in patients with severe illness.

Equally, the authors reported, chronic fatigue-type symptoms have been associated with the SARS infection in 2003, and are common in the aftermath of a spectrum of infectious diseases.

However, they found severity of the disease is not a predictor of long COVID. The Norwegian study observed the after-effects of COVID in both hospitalised and home-isolated patients with mild symptoms. Of the 312 patients studied, the median age was 46 years with 51 per cent women. Forty-four per cent had comorbidities, the most frequent being chronic lung disease, hypertension, chronic heart disease, rheumatic diseases, diabetes and immunosuppressive conditions. Only about 20 per cent of those with symptoms during the acute COVID stage had fever.

Significantly, it found a large proportion of survivors of COVID-19 had persistent symptoms six months after their initial illness. 'It is worrying,' the researchers wrote, 'that non-hospitalized, young people (16–30 years old) suffer potentially severe symptoms, such as concentration and memory problems, dyspnoea and fatigue, half a year after infection.'

The Norwegian study found a high prevalence of persistent fatigue in patients with COVID-19 – higher than observed after common infections such as influenza, Epstein-Barr virus and dengue. It found 61 per cent of the study population had persistent symptoms six months after initial COVID-19 illness, with the most common symptoms being fatigue (37 per cent), difficulty concentrating (26 per cent), disturbed smell and/or taste (25 per cent), memory problems (24 per cent) and dyspnoea (21 per cent). Even among the 247 home-isolated patients, 55 per cent experienced persistent symptoms at six months, most commonly fatigue, disturbed taste and smell, concentration impairment, memory loss and dyspnoea.



A longitudinal study by Thomson, Williams et al of more than 6,000 long COVID patients identified risk factors based on sociodemographic and pre-existing health factors. A range of studies have found long COVID is particularly prevalent among middle-aged people, especially women, people with chronic lung disease (mainly asthma), obese or overweight people, and people with pre-existing mental health problems.

While the causes of long COVID remain unknown, there is some suggestion that it may be an autoimmune response in some people causing damage to cells, explaining symptoms such as brain fog, loss of taste and smell as well as damage to blood vessels leading to heart, brain and lung problems.

Alternatively, fragments of the virus could remain, becoming reactivated after lying dormant. In particular, some researchers are exploring whether the herpes Epstein-Barr virus, linked to glandular fever and chronic fatigue, could be reactivated by COVID, causing long COVID symptoms.

Others suggest that long COVID could be several disorders rather than one.

With no test for long COVID, diagnosis is made via elimination. However, a pilot study by Imperial College London has found irregular antibodies are common in blood samples of people suffering with long COVID, which lead researcher Professor Danny Altmann says could pave the way for a blood test.

Currently, there are no treatments for long COVID, although some are being tested, including a clinical trial of deupirfenidone, an anti-fibrotic and anti-inflammatory agent.

GP funding overdue for reform

The AMA is calling for more funding for general practice, especially with the additional pressures imposed by the pandemic.

The AMA has welcomed the release of a draft reform blueprint by the Federal Government's Primary Health Reform Steering Group while calling for extra funding and support for Australia's general practitioners.

AMA President Dr Omar Khorshid says the pressures on GPs are mounting, as they continue to deliver care to a community increasingly burdened by chronic disease and with the load imposed by pandemic-related vaccinations, counselling and disease.

With Australia's population growing, ageing and having more complex physical and mental health needs, the AMA says reform will be meaningless unless it is backed by substantial Commonwealth investment. Under successive governments, funding for general practice has not kept up with demand or the increasing costs of providing care.

The AMA broadly agrees with the intention and direction of 20 draft recommendations that will inform the government's 10-year plan for primary health. In supporting these, the AMA has called on the Commonwealth to mandate expenditure on general practice at 16 per cent of its total health expenditure. Currently less than 13 per cent is spent on general practice.

This approach has been adopted in Oregon in the United States, with every additional dollar spent in primary care saving $13 in other parts of the health system.

The AMA submission highlights GP services are being systematically devalued through inadequate indexation of the Medical Benefits Scheme and a consultation item structure that 'fails to keep up with the growing complexity of care and the need for GPs to spend more time with their patients'.

The AMA is also calling for a for a GP-led governance structure to be put in place to implement the government's 10-year primary care plan once it is finalised.

'We welcome proposals to reform of funding arrangements for general practice as part of efforts to improve and strengthen primary care,' says AMA President Dr Omar Khorshid.

'The Medicare fee-for-service model works well in most situations, but we need to look at supplementing this with other funding streams that recognise the growing complexity of care and the need to encourage a greater emphasis on prevention.

'We're pleased to see draft recommendations call for the doctor-patient relationship to be formalised through Voluntary Patient Enrolment, with current government plans to implement this delayed due to COVID-19.'

The Commonwealth set aside $448.5 million to support VPE in general practice in the 2019/20 Budget, with this funding also being delayed.

'With growing pressure on general practice, the government urgently needs to finalise plans to spend this much-needed funding so that it flows to support improved access to care as quickly as possible.,' Dr Khorshid says.

'VPE or voluntary GP nomination and funding reform are key parts of the General Practice pillar of the AMA's Vision for Australia's Health.

'When we launched our plan for a future-proofed health care system in June, we said that properly resourced, general practice has the ability to transform and innovate and generate savings that can lower the burden on other more expensive parts of the health system.

"The good thing about the recommendations is that they recognise the central role that general practice plays in our health system, and that strengthening this even further will support better health care outcomes and help keep our health system sustainable.'

The Federal Government's Primary Health Reform Steering Group's draft recommendations reflect much of the AMA's 10 Year Framework for Primary Care Reform released in July 2020, in which it stated increases to funding are needed to ensure the economic sustainability of general practice in the face of an ageing population burdened by chronic and complex disease. The toll of COVID-19 has placed additional pressured on GPs since then, he says.

'General practice has been neglected for too long and the Government must ensure that these recommendations do not sit on a shelf gathering dust. These recommendations need to be urgently translated into a concrete plan that has real actions, timelines and funding attached,' Dr Khorshid says.

The AMA's full response to the draft recommendations of the Primary Health reform Steering Committee can be read on the AMA website.

Image credit: SDI Productions, iStock

RTWSA changes questioned

AMA(SA) has called for expert medical and legal input into any changes to the RTWSA workers' compensation scheme.

The Australian Medical Association (SA) has urged the Minister for Industrial Relations to scrap proposed changes to Return to Work SA's Impairment Assessment Guidelines (IAG) and go back to the drawing board – this time with input from doctors, lawyers and other professionals.

In a letter to the Minister, AMA(SA) President Dr Michelle Atchison expressed grave concerns about the process used to develop the draft guidelines that will limit compensation for injured workers, noting that relevant clinicians had been left in the dark about the changes.

A letter to RTWSA outlined AMA(SA) concerns raised by members of the AMA(SA) RTWSA Reference Group, which includes representatives of medical specialties involved in the assessment process. It was followed by a letter to Industrial Relations Minister Rob Lucas, whose portfolio includes RTWSA matters.

The proposed RTWSA changes automatically deduct 10 per cent from an injured worker's assessment for a lump-sum payment if they have a pre-existing injury – which most people from middle age are likely to have. They also require surgeons, rather than the patient's choice of doctor or occupational physician, to assess the impairment post-operatively.

Dr Atchison suggested that relevant experts had been excluded by the process and given limited time to respond to the 129-page draft review, with only four weeks to consider complex changes to protocols and clinical decision-making and information sessions provided just two weeks before the closing date for submissions.

'We have to ask to what degree the guidelines' development was based on a desire to cut costs, rather than to ensure improved outcomes for injured workers,' Dr Atchison said.

The AMA(SA) submission noted:

'These are substantive changes that should be scrutinised by colleges, faculties and technical advisory groups with knowledge in specialist medical fields such as pain management and musculoskeletal injury. The feedback of these clinicians should be a critical component of the development or redrafting of guidelines.

'The consultation process is too short for us to adequately consult among ourselves to consider the individual items of concern and offer a reasonable response.'

In a letter to Mr Lucas, AMA(SA) said its expert reference group was 'perplexed at how the guidelines had been developed, and by whom. They were not aware that any of the main parties involved in the assessments had expressed serious concerns with the existing guidelines; nor were they aware of any invitations addressed to themselves or their colleagues to review or change the existing guidelines'.

Under the existing guidelines, a worker with an injury affecting more than five per cent of their bodily capability is entitled to a lump sum payment and ongoing income payments as well as a lump sum if their affects more than 30 per cent of their bodily capability.

Reasons questioned

AMA(SA) members are concerned about the proposed changes to whole person impairment (WPI) assessment, arguing that changes such as the removal of scarring have been proposed solely to reduce the cost of the scheme, without considering how other system changes could contribute to budgetary objectives.

'We note the proposal to introduce a blanket 10 per cent reduction in compensation where there is a pre-existing condition that may contribute to WPI. While we recognise this figure is used in other Australian jurisdictions, we would like to see evidence of its relevance to South Australian cases.'

Dr Atchison also said members strongly opposed any recommendation that the assessment of a musculoskeletal injury must be by a surgeon accredited in the relevant body system.

This would discriminate against non-surgical assessors and undervalued the accumulated knowledge about a person's injury and rehabilitation, she said.

'For example, a pain patient with Complex Regional Pain Syndrome and a surgically implanted stimulator, would perversely have a surgeon with limited knowledge or understanding of pain syndromes', the AMA(SA) submission warned.

'In addition, it may also lead to more "fly in, fly out" assessors at greater cost and possibly distress to the patient.'

The AMA(SA) has requested that the Minister 'suspend further action in relation to these draft guidelines, and – if and when changes are subsequently deemed to be necessary – begin a review process that starts with and maintains input from the medical, legal and other professionals involved'.

Clinicians' review needed

'It appears to us that the overall purpose of these changes is to reduce the cost of the scheme: for example, because surgeons provide lower assessments of residual disability than rehabilitation and occupational physicians. If this is the case, AMA(SA) members suggest RTWSA review these aspects of the scheme, with our input, and address any disparity highlighted by objective analysis,' the submission noted.

The AMA(SA) says that while various proposed changes have merit, including the proposal to evenly distribute assessments among assessors to avoid multiple assessors and decrease waiting times, the review requires more expert input. For example, the AMA(SA) advocates amending the legislation to randomly select an assessor from the list of trained and approved assessors. In addition, the referrer could be de-identified so that the assessor can be truly independent.

Other procedural improvements have also been recommended including:

- external compliance monitoring
- consistency of documentation including referrals, reports that are concise, simple and structured
- appropriate fees for Independent Medical Examinations (IMEs) which attract the same fee as permanent injury assessments (PIA) although the former are more complex and demanding to prepare
- an extension of time allocated to an assessor for clarification of a report up from five to 10 business days, with allowances for exceptional circumstances such as the assessor being on leave.

AMA(SA) calls for negative pressure rooms

Patients, staff and visitors in obstetrics and gynaecology (O&G) departments in major metro hospitals are being placed at greater risk of COVID-19 due to a lack of dedicated negative pressure rooms, AMA(SA) has warned.

AMA(SA) President Dr Michelle Atchison has asked Health and Wellbeing Minister Stephen Wade to make negative pressure rooms available in O&G departments for infectious patients, after AMA(SA) Council members raised the alarm.

Negative pressure or isolation rooms help prevent the spread of infectious diseases by preventing the flow of dangerous particles into the higher pressure, non-contaminated area outside the room. Instead, non-contaminated filtered air flows into the negative pressure room while contaminated air is sucked out with filtered exhaust systems.

In Australia, these negative pressure rooms are expected to comply with the guidelines outlined by the Australasian Health Infrastructure Alliance.

This is particularly important with airborne diseases, which COVID-19 is now understood to be.

'Our advice is that there are insufficient negative pressure rooms to maximise the health and safety of women in maternity wards in the state's hospitals,' Dr Atchison said.

'This is placing women, babies, visitors and hospital workforces at unnecessary risk in the COVID-19 pandemic.'

Dr Atchison asked for an audit and steps to ensure all hospitals have negative pressure rooms, with these facilities provided specifically for maternity patients in addition to any provided for other wards.

The AMA(SA)'s O&G members say women in labour, babies, and staff are at increased risk because:

- labour and delivery have high risks of droplet/aerosol transmission
- women in labour require constant, close contact care from their midwife or doctor and possibly other clinicians and health workers
- labour cannot always be planned, so a negative pressure room must be ready for O&G patients at all times
- there is increased demand on birthing units due to a rising birth rate.

AMA(SA) says negative pressure rooms dedicated to O&G departments that were required as facilities in other wards, such as intensive care units, are not appropriate for women in labour who are otherwise well, and these facilities are likely to be needed for other unwell patients.

'This pandemic requires the whole health service in South Australia to work together to minimise risk for patients and the workforce,' the submission says.

'It has been increasingly obvious that COVID-19 spreads through airborne transmission. As we see mounting evidence of the risk of airborne transmission, it is important that careful risk assessment and infection control measures are implemented to keep the workforce, patients and visitors as safe as possible,' it notes.

This measure would bring these departments into line with other jurisdictions nationally and globally which have adopted infection control measures to manage airborne transmission based on emerging evidence and pressure to strengthen infection control and protection policies.

Consistent with Australian Government Department of Health recommendations, and in light of the presence of the highly contagious Delta variant of COVID-19, AMA(SA) has asked that, negative pressure rooms should be used for:

- the isolation of hospitalised patients with severe acute respiratory symptoms, and/or probable or confirmed COVID-19 infection
- aerosol generating procedures with presenting patients (general practice, hospital, emergency department, clinic, or pathology collection centre) with acute respiratory symptoms, and/or suspected, probable, or confirmed COVID-19 infection.

Prisons need vaccination supply

AMA(SA) has written to Health and Wellbeing Minister Stephen Wade to ask that prisoners and prison officers not be forgotten in the COVID-19 vaccination rollout.

In a letter to the Minister, AMA(SA) President Dr Michelle Atchison thanked the government for its efforts to vaccinate South Australians 'in complex and challenging circumstances', but advised that there were reports that the populations of the state's correctional facilities had not been prioritised for vaccination.

Dr Atchison asked for assurances that the residents and workforce of South Australia's prisons and correctional facilities are receiving age-appropriate COVID-19 vaccinations.

She offered AMA(SA) assistance in managing the process of rolling out the vaccine in the correctional services sector if needed.

In the letter, Dr Atchison asked for detail about 'what we hope is a focused and rapid vaccination rollout in the state's correctional facilities'.

She said any delay in vaccinating correctional services personnel could have serious repercussions for individuals and the broader population.

'I am sure you are aware of international evidence, particularly from the US, that demonstrates the risk of rapid infection with this airborne virus within prisons, and the health risk that poses for all people in and in contact with these facilities – including members of vulnerable population groups such as Indigenous people. The presence in Australia of the more contagious Delta variant multiplies this risk,' Dr Atchison wrote.

In the US, a number of research projects have tracked more than 500,000 people living and working in prisons who became sick after being infected with COVID-19.

They reported that prisons found it difficult to implement measures to manage the unusual and deadly circumstances related to the virus, with limited opportunities to humanely distance prisoners.

In Australia, the Human Rights Law Centre (HRLC) has warned that solitary confinement is likely to be deployed as a response to the 'devastating' impact of the pandemic in prisons, particularly considering the pre-existing medical conditions experienced by many people in Australian prisons.

WCH plans 'incompatible' with doctors' work

AMA(SA) is calling for more clinical input into the next stages of planning the new Women's and Children's Hospital to ensure it meets existing and future demand.

Clinicians have warned that the 'consultation' processes involved in planning the proposed $1.95 billion Women's and Children's Hospital have been 'merely a token effort'.

Staff members say the proposed design does not meet current or future needs.

'We don't believe the planned hospital will allow us to provide the community with high-quality services in a safe, efficient way,' doctors say. 'It is even more difficult to see how it could expand to meet future demand.

'Genuine clinician engagement is the only way forward from here. Hopefully, it is not too late.'

While the state government has emphasised that it has changed the design in response to clinicians' concerns about whether it is fit for purpose, staff say attempts at what is referred to as 'consultation' do not feel genuine.

'We don't doubt that there is good will and enthusiasm on the part of the project team, but it feels as if we have been simply going through the motions,' AMA(SA) Council says. 'We are listened to and what we have to say is documented, but without any genuine commitment to incorporating our suggestions.'

In a letter to Health and Wellbeing Minister Stephen Wade in April 2021, then AMA(SA) President Dr Chris Moy said AMA(SA) Councillors had expressed ongoing concerns about the hospital design, including its capacity, internal supply processes and capacity to expand.

He outlined as specific concerns:

- bed capacity and capacity to provide services such as emergency and outpatients
- shortage of physical space for patients, families, clinicians, and staff
- provision of catering, sterilisation, pathology and diagnostic imaging and concerns that these may be transferred to the Royal Adelaide Hospital
- limitations of the proposed build and site that may restrict scope for expansion
- a perception that clinician input has not been genuinely listened to
- lack of access to the data – both current and projected –upon which the design and capacity of the hospital have been based
- that the capacity of the hospital is being based on average bed needs with no redundancy.

In a written response, the Minister said the government had increased the number of treatment spaces from 445 to 500 in response to clinical input, and was committed to genuine consultation.

'Some clinicians raised concerns that the planned treatment spaces did not fully consider or account for a range of current and future factors that would impact their ability to continue to deliver high-level care to their patients,' the Minister wrote.

In response to feedback, he said, two dedicated workshops with clinicians and executives were held in May 2021. It was agreed that the new WCH should have a clinical capacity of 500 admitted treatment spaces and 170 outpatient consulting rooms.

Now, staff say that even with the additional treatment spaces, the proposed model does not factor in future growth – particularly when the Bragg Proton Beam Therapy unit is open and attracting patients from around the country and overseas.

'Bed capacity and treatment spaces are probably sufficient right now, but growth is inevitable,' doctors argue. 'We need to address how services will be different 10 years from now.

'If medical staffing were to increase to meet true current need, including addressing large backlogs of outpatients, more beds, treatment spaces and staff would immediately be required.

Totally unacceptable

'We believe we can't progress the accommodation until the gap analysis has been completed, which we are told will take around 12 weeks. In other words, the data on which the design and capacity are based are flawed.

'While "expansion spaces" exist in the plan, these are neither plentiful nor ideally located. We anticipate that cancer patients will overflow to the general paediatric ward and medical patients to the surgical ward. We've been told this will be addressed in the design phase,' they say.

The proposed model of care for outpatient services has also been equally criticised as 'totally unworkable', with as many as five departments or units expected to share eight outpatient consulting rooms.

'Bear in mind, there will be no capacity to see "overflow patients" in our office space. Shortage of physical space is also a concern, with room dimensions still not confirmed,' the staff say.

'What is proposed in the draft is totally incompatible with the way we work and will inevitably lead to serious inefficiencies and negatively impact patient care and safety.'

Staff have also raised concerns about the proposed changes to departmental structures with a centralised administration. 'With no dedicated staff, departments will have no direct interface with the public and corporate knowledge of our patients will be lost,' they say.

'We are concerned that communication with families will be far less efficient and our ability to meet their needs in a holistic way will be undermined. This too will impact on delivery of high-quality patient care and patient safety.'

Doctors warn the process has been flawed from the beginning and the changes to date have not been made transparently.

'Clinicians have readily engaged but enormous effort on our part has translated into small changes only. The trajectory doesn't change. We assume this is because most major design decisions have already been made,' they say. 'There has been little interface with the design team and other key groups – the meetings have been with the "middle layer".

'It has become increasingly difficult to secure agendas and vital documents, most recently the schedules of accommodation (SOA), in a timely manner prior to meetings,' say clinicians. 'In short, this doesn't feel like a genuine partnership.'

Clinicians also expressed concern that members of important committees and workshops seemed to be hand-picked, leading to a perception of bias.

SA Health blueprint

Work on the new Women's and Children's Hospital (WCH) within the biomedical precinct on North Terrace is expected to begin in 2022. The Master Plan released in June 2021 identified features including:

- 500 treatment spaces – 59 more than the existing WCH
- an Emergency Department (ED) with 43 treatments spaces (up from 24)
- more beds, neonatal cots, theatres and recovery bays
- 170 outpatient consultation rooms (increase of 30)
- 14 Women's Assessment Service spaces
- In-room accommodation suites, including bedrooms with ensuite bathrooms
- Parent lounges near Newborn Intensive Care Unit
- Two air-link bridges to connect the nWCH to the RAH for use of the helipad, Intensive Care Unit and other clinical services
- a bridge over the rail line that will connect the site to the western Park Lands and the new multi-level car park
- 1,215 car parks - almost double capacity of the current site
- disability and pram parking close to the hospital
- main entry on Level 3, with views to the western Park Lands and access to a landscaped play space, retail and consumer facilities
- emergency vehicle access to the ED at the rear of the hospital
- about 108,000 sq m in total - up from 96,000 sq m (excluding carpark and outdoor space)
- 12 floors
- more outdoor space, respite areas and children's playing areas
- Australia's first 100 per cent electric hospital.

Evidence should guide suicide prevention

Resources to introduce legislation to reduce suicide rates in South Australia would be better used in other ways, AMA(SA) says.

Introducing anti-suicide legislation would be a waste of time as there is no evidence that it does what it sets out to do, the AMA(SA) has advised the South Australian Government.

In a submission to the Health and Wellbeing Minister Stephen Wade, AMA(SA) has said there is no evidence that legislation is necessary or effective as a measure to reduce suicide rates.

Instead, the then President of the AMA(SA), Dr Chris Moy, said the government should pursue strategies and policies that focus on evidence-based responses.

'The AMA(SA) recognises and appreciates that the intention of this Bill is to reduce the incidence of an event that is always complex and distressing. However, we suggest that this is not an approach that evidence indicates has been successful elsewhere in the world," Dr Moy wrote.

'The significant resources that would be required to implement this Bill and the many plans entailed would be better directed at developing such interventions, and at examining and improving the conditions that may lead people with mental health issues to contemplate suicide.'

Such an approach would align with recent reporting by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) which notes that 'clinical interventions are the most effective approaches'. It recommends 24-hour crisis care, mental health training for frontline health and community workers, and efforts to systematically reduce societal inequalities.

'We welcome and support strategies, policies and funding that focus on effective training and evidence-based responses, and the collection and analysis of suicide-related data to help governments and health practitioners understand the scope and patterns of suicide and to evaluate prevention efforts,' the AMA(SA) submission explains.

'We are unconvinced that legislation is needed to prevent suicide.'

No significant impact

Japan in 2006 became the only jurisdiction known to have introduced such a measure. In Japan, a study of the legislation's impact on reducing suicide rates has found 'the difference in trend between before and after implementation of the Suicide Prevention Act was not significant for overall and for sex-age/-specific populations'.

The submission pointed to research that shows that suicide rates change little within a specific sociocultural context.

Despite national and state interventions and strategies to reduce the rate of suicides in Australia, a review by internationally recognised psychiatrist Professor Anthony Jorm shows these have made no discernible difference.

Professor Jorm's 2020 research examined the impact of interventions on suicide rates and why interventions do not have a major effect on suicide rates.

Social factors dominant

He concluded that 'there are major social factors affecting the suicide rate (and that) mental health interventions are not likely to have a major impact on these social factors', which include the loss of employment, financial crisis, relationship breakdown, trouble with the law, and the availability of alcohol and other substances.

Professor Jorm recommended that resources be directed to:

- developing and evaluating treatments that specifically target suicide reduction
- interventions that operate 'on the spot' to reduce risk where suicidal feelings arise suddenly and actions may be impulsive, including those that help people in the suicidal person's social network develop the capacity to intervene and technological solutions such as mobile phone apps.

The AMA(SA) submission flags support for the proposed Suicide Prevention Council as a way of collecting and sharing information and expertise but says legislation is not required to form such a group.

The submission notes that the AMA(SA) would welcome the introduction of a data collection and management system, including a register of suicide-related data, along the lines of that launched in NSW.

'However, we suggest the collection and analysis of such data can and should be a component of broader improvements in data collection, analysis and sharing within and across the South Australian health system,' it says.

The AMA(SA) supports a state approach that provides services for people with mental health issues, including suicide, and which leads research, training and data collection through a plan or strategy – but again questioned the need for legislation.

It warns the proposal for legislated suicide prevention plans within an unknown number of 'prescribed State authorities', will be cumbersome, costly and punitive.

'Each agency would have to allocate funding and resources to developing and implementing these plans, and then possess the expertise to monitor and evaluate compliance and results. Again, we recommend that the funding that would be required to implement this proposal be directed at mental health services and training, and the improvement of social conditions for those at risk of mental ill-health,' the submission says.

The submission notes the potential for unintended consequences: 'It would concern us if the introduction of legislation designed to minimise suicide did, in fact, create bureaucratic procedures that divert attention and resources from the individuals suffering mental health issues and those trying to help them'.

'Governments listen to the AMA'

Dr Omar Khorshid

AMA President Dr Omar Khorshid delivered the AMA President's address during the Plenary Session of the AMA National Conference on 31 July. This is an excerpt of his address.

'It is an enormous privilege to represent the medical profession at any time, but even more so as AMA President in a pandemic, when health issues are at the front of every Australian's mind and when Australians are looking to their doctors for advice, for comfort and for leadership.

The medical profession these last 18 months has made an extraordinary contribution to the health and wellbeing of the community during the pandemic. Our workloads have increased, and we have not felt safe at work. Many work practices have been re-written. Our patients and our colleagues have been more anxious, our already stretched health system has been asked to do more and more, and governments have been slow to act.

Doctors, like many Australians, are exhausted. They're exhausted by uncertainty, they're exhausted because they've not had decent downtime, and they're exhausted by unreliable vaccine supply, infection outbreaks and the consequences of repeated lockdowns.

Public elective surgery has been disrupted. Private hospital surgery has had stops and starts. Patient care has been interrupted.

Yet our medical profession has risen above these pressures. Doctors have been leading our nation through this extraordinary experience.

The AMA's strategy in response to COVID has been to ensure that the voice of doctors informed government decisions. We have also spent a huge amount of time talking directly to the public, translating the science, supporting government decisions and having conversations with the community through TV, radio, newspapers and even social media.

The AMA Federal Council and I have acted to ensure doctors and healthcare workers are safe in their workplaces. Early in the pandemic, the focus was on securing sufficient and appropriate PPE for healthcare workers in both hospitals and private practice and later, appropriate guidelines for their use. Some of those efforts took far longer than we had hoped, with appropriate guidelines that recognised airborne spread only recently having been agreed. But we got there in the end, and thankfully before Australia experienced a second very large outbreak. We have argued governments must be clear and consistent in their communication to the public. This is still an area requiring improvement.

In tangible deliverables for doctors and their patients, the AMA worked with Greg Hunt early on to rapidly introduce telehealth through the MBS. I stood next to the Minister last October in Parliament House when he announced that telehealth from that point on would be permanent part of our health system. We're still waiting to see exactly what permanent telehealth will look like, but the commitment from government is clear and public.

The AMA secured a pledge from the Prime Minister to establish a vaccine compensation claims scheme. The AMA secured new MBS item numbers for GPs to visit aged care recipients, vaccine discussion item numbers, and we've ensured GPs have been the front line of the vaccine scheme.

But we are not government. We're critical of many decisions of government and we've had to say so but at the same time being careful not to undermine the vaccine strategy nor the public health response. Vaccine supply difficulties, in particular, have made just about every GP despair at some point, especially those directly involved. Lockdowns have undoubtedly saved lives, but they have also created financial and mental health burdens for many, including many members of our profession.

Yet with all this pressure, with all the disruption, the medical profession has remained focused on patients first. It is hard to predict what to expect from the pandemic in months and years ahead. But we know the medical profession will continue to put patients first. The AMA has been doing that, and also will put our members first, and go into bat on their behalf, no matter the circumstances.

The key question is, how would life be for doctors and their patients if the AMA did not exist? Let me paint a picture. In just my last year as President, if the AMA did not exist, I doubt general practice would be the dominant home of the COVID vaccination program. A vaccine compensation claims scheme would not have been agreed. GPs would not have extended consultations to support vaccine-concerned patients.

Beyond the immediacy of COVID, permanent telehealth in the MBS would remain a pipe dream, the rights of bonded practitioners and students would remain unresolved, GPs would not have the expanded roles in residential aged care that we are working towards, and vaping products would likely be commonly available. Surgeons and other proceduralists would have lost the benefits of the prostheses lists to their patients and would have to negotiate with hospitals around access to appropriate prosthesis options that suit their practices.

Without the AMA, the voice of doctors in the town square would be silent. Colleges, speciality associations and valued medical groups such as Doctors for the Environment would continue to pressure governments on priorities for the profession in the areas of interest to them, but – let's be blunt – governments listen to the AMA. It's why I, the Board, and the state and territory AMAs have been working on our long-term future, on how we can engage more doctors in our work, and how we can be positioned to meet the changing demographics and evolving interests of our members and future member as time goes on.'

A grand Fellow

Associate Professor William Tam at AMA(SA) Council in June

The AMA added former AMA(SA) President Associate Professor William Tam to its Roll of Fellows, with the following citation presented during the AMA National Conference.

'Associate Professor William Tam is an eminent gastroenterologist, interventional endoscopist, and past president of the Australian Medical Association (South Australia), and a unifying force for the Association. Holding key leadership roles in the AMA and the Australian Chinese Medical Association for more than a decade, he has been a champion of the medical profession in issues of public importance. Bilingual in English and Mandarin, Associate Professor Tam has meaningfully engaged with people of many cultures and backgrounds, drawing doctors to the AMA and working for colleagues' issues and patients' care.

Associate Professor Tam has maintained senior leadership roles in the health sector as Deputy Head of Endoscopy at the Royal Adelaide Hospital and Senior Clinical Lecturer at the University of Adelaide, as well as participating in a number of committees. He is the current chair of the Australian Gastrointestinal Endoscopy Association (AGEA) and state reference member of the Australian National Bowel Cancer Screening Program. A lauded clinician, with awards including the Royal Australasian College of Physicians Bushell Travelling Scholarship, Associate Professor Tam has maintained a prodigious program of research and teaching. He is a previous head of department at the Lyell McEwin Hospital and has supervised many trainees across the state over the years. In private practice, as one of the founders of Adelaide Gastrointestinal Specialists, Associate Professor Tam regularly provides specialist services to the Kangaroo Island community and support to the island's hospital.

Associate Professor Tam is an internationally recognised clinician and researcher with a PhD in reflux disease and Barrett's oesophagus that led to further training in Amsterdam and Tokyo. He graduated from the University of Adelaide with a Bachelor of Medicine, Bachelor of Surgery in 1994 and became a National Health and Medical Research Council Research Fellow, receiving a PhD from the University of Adelaide in 2005. He was made a Fellow of the Royal Australasian College of Physicians in 2000. Associate Professor Tam became a Fellow of Gastroenterology at Middlesex Hospital in London in 2003 and an honorary lecturer at the University of London, advancing his skills in therapeutic endoscopy. He is widely published in the leading journals of his discipline on topics ranging from gastric metaplasia in the duodenal bulb to real-time histology with the endocytoscope. He has a chapter in the text Clinical Problems in General Medicine and Surgery 2003, edited by P. Devitt, J Barker, J Mitchell and C. Hamilton-Craig, and has published a host of case reports in leading refereed journals.

Associate Professor Tam became an AMA(SA) Councillor in 2012 and joined the inaugural AMA(SA) Executive Board in 2013. He became vice-president of the Australian Chinese Medical Association in 2008 and was elected as its president in 2010 – a position he still holds.

As president of the AMA (South Australia) from 2017 to 2019, Associate Professor Tam stewarded the Association through a particularly challenging period for the public health system in South Australia, with major change projects including the new RAH, Transforming Health, the proposed new Women's and Children's Hospital, and SA Health's electronic records system. He also engaged with the then-new Liberal Government's plans to decentralise governance of the public health system. His intervention secured public pathology services that became critical during the recent COVID pandemic.

As President, Associate Professor Tam was the voice of reason on behalf of clinicians – including those bound by contractual constraints – and demonstrated great personal courage and diplomacy while challenging policies and decisions perceived to be detrimental to patients and the health system.

As a member of the AMA(SA) Executive Board, Associate Professor Tam has helped guide the Association through a period of financial stress and internal conflict, helping re-position it for growth. He has demonstrated wisdom and resolve, provided a steadying influence at a time when the Association was experiencing controversy, and oversaw a process of restructuring within AMA(SA).

In his AMA(SA) leadership roles, Associate Professor Tam has been an enduring advocate of data and research as the bases for decision-making and has sought views across a wide cross-section of the medical community before representing these views, on behalf of the Association, to government. His corporate knowledge on the Board is said to be unparalleled and he is steadfastly resistant to 'group think' – he can always be relied upon for a considered opinion, formulated after he has taken time to reflect on the opinions of those around him.

His personable style, intellect and warmth have brought doctors from all areas and cultural backgrounds to the AMA and he continues to be highly regarded and 'loved by pretty much everybody'. Associate Professor Tam is recognised for his courteous, calm demeanour, engaging humour and a rare ability to make everyone feel important to him. His sunny disposition, coupled with a sensible approach, are highly valued in moments of pressure – perhaps best demonstrated by his ability to continue delicate keyhole surgery when the lights unexpectedly went out in theatre at the new RAH in 2018. He is, quite simply, a wonderful example of the enthusiastic and selfless dedication for which the AMA is renowned.'

New shingles vaccine available in Australia

A new and more effective vaccine to prevent the painful shingles virus (acute herpes zoster) in people over 50 – and among the immunocompromised people who need it most – is now available privately in Australia.

Immunisation Coalition chair Dr Rod Pearce says the Shingrix vaccine, a recombinant zoster vaccine, is more effective than the currently used live vaccine and can be used by immunocompromised people who are both more likely to get shingles and to have severe cases.

Dr Pearce says those with an immune deficiency are unable to have the live vaccine, as it is likely to make them ill. It is also contraindicated for pregnant women and individuals with an anaphylaxis response.

Shingles can affect up to one in three people at some stage in their lives, with the risk increasing with age. About 120,000 new cases of herpes zoster occur each year in Australia and the disease accounts for approximately one in 1,000 of all GP visits.

In most cases, shingles resolves on its own. However, it can be extremely painful, with burning, shooting or stabbing pain that lasts for between two and four weeks, and potential complications and chronic pain for months (postherpetic neuralgia). The risk increases substantially after the age of 50 and people aged over 70 are particularly vulnerable to shingles and postherpetic neuralgia.

Acute herpes zoster or shingles is caused by reactivation of latent varicella zoster virus or chicken pox. About 30 per cent of people with shingles develop postherpetic neuralgia (nerve pain), which is extremely painful and can last for months. Ageing and immunosuppression from disease or medical therapy are the main triggers for this response, as the varicella zoster virus-specific cell-mediated immunity declines.

Shingles can be treated with antiviral therapy (valaciclovir or famciclovir) within 72 hours of the rash onset to help the pain and heal the skin lesions. However, the treatment appears to have little or no effect on the likelihood of developing postherpetic neuralgia.

'This new Shingrix vaccine is a game changer. It continues to work in older people, and it continues to show that its working with people with immune deficiencies associated with chemotherapy or other treatments,' says Dr Pearce.

Clinical trials showed Shingrix provided 97 per cent protection against shingles for 50-59-year-olds and 91 per cent for those aged over 70. Similar levels of protection were observed against postherpetic neuralgia over more than three years. In comparison, the live vaccine efficacy against shingles was 51 per cent and against postherpetic neuralgia was 67 per cent over three years of follow-up.

Professor Paul Worley

'Home grown' doctors to fill rural gaps

A new medical model aims to develop a 'home grown' workforce in response to the continuing rural doctor shortage, writes former National Rural Health Commissioner Professor Paul Worley.

The Riverland Mallee Coorong Local Health Network (RMCLHN) will in January 2022 start offering full-year intern training to five domestic graduates of local rural clinical school programs.

The RMCLHN is working with local GPs and other specialists to take responsibility for training our own clinical workforce. By creating and improving relevant evidence bases for our clinical practice, and bringing the benefits of integrated teaching, research and clinical care to the communities in our region, we will nurture our own locally grown rural health workforce.

The vehicle for this transformation is the Riverland Academy of Clinical Excellence (RACE). This newly formed academy aims to boost clinical training of the medical workforce and generate exciting opportunities for research and innovation.

The region between the River Murray and the Victorian border is one that embraces innovation. Through the Parallel Rural Community Curriculum (PRCC) program, Flinders University has supported medical students to study for a year in the Riverland since 1997. This program was the first of its kind in Australia and has been successful in increasing the interest of students in a rural medical career. It was the model for the national Rural Clinical School program and has been imitated by medical schools in many countries.

However, students who complete the PRCC currently must return to the city to complete their final year of medical school. Many do not return to the region to pursue rural medicine.

In recent years, recruiting registrars back from the city has been increasingly difficult and the numbers of GP registrars in the region has fallen significantly, challenging the already overstretched GP workforce. This 'disconnected' approach to rural medical training has led to crisis after crisis, made worse by the extreme workloads during the COVID-19 pandemic.

We will no longer look to others for solutions. Instead, our plan is to work with Flinders University as a long-term partner to solve the region's medical workforce deficit and create medical student, junior doctor and registrar training, through to a rural generalist fellowship based in our region. Our linked approach, led by the LHN, supported by the university, and aligned to the National Rural Generalist Pathway principles, will provide a dynamic, sustainable rural generalist workforce for our future. It will increase the attractiveness of the region to other specialists that will support our core rural generalist workforce.

RACE articulates RMCLHN's ambition to be a centre of excellence in rural health and highlights our commitment to medical education in our region and counteracting medical workforce shortages. It is a multidisciplinary division within the Riverland Mallee Coorong LHN, using medicine as a lever for change to the whole rural health workforce.

Foundations laid for success

So, how did we get here?

Over the past five years, the foundations have been laid, progressively and deliberately – salaried medical models of consultant staff to enable junior doctor supervision and employment; new models of care led jointly by resident rural generalist and other specialist consultants; enhanced clinical governance, particularly of the inpatient staffing model and, more recently, the emergency department at Riverland General Hospital; appointing a practising rural generalist as the Chair of the RMCLHN Governing Board; and appointing a practising rural generalist as the Executive Director of Medical Services.

Similar to the Murrumbidgee Model, RMCLHN is committed to providing five-year contracts on a single-employer model for the duration of postgraduate training, through to GP fellowship with RACGP or ACRRM. The key to our success, however, will be that our students and trainee doctors will call the Riverland Mallee Coorong region 'home'. This will be where they forge their social and professional relationships, learning from their peers and mentors, which are so important in career decisions. In this way, we are recognising that the Indigenous concept of 'country' will be fundamental to our work.

The first new shoots are now appearing. Our inaugural five interns will start working with us in January 2022 – all locally trained graduates with at least a year of rural clinical training already under their belts. Building on our existing Obstetrics Advanced Skills Training (AST) program, we are developing mental health, surgery, emergency medicine and adult medicine ASTs to be available in 2022. Our first collaborative clinical trial with SAHMRI, investigating the impact of ultraviolet filtration on airborne viral pathogens in aged care facilities, is about to start. Joint appointments between the university and health service have been advertised. Joint R&D with GPEx is in motion. New teaching facilities at our Berri campus are being built. Journal clubs have started, clinical leadership meetings have commenced, and grand rounds are next.

In time, we hope to not just develop the rural workforce of the future for the Riverland Mallee Coorong region, but to also export rurally trained clinicians to other regions of South Australia.

If you want to be part of reclaiming rural sovereignty for our medical workforce supply chains, work with a generation who see opportunity rather than disadvantage, and be part of the solution, come and join us as we serve those who deserve our absolute best – the rural communities that form the backbone of South Australia.

Wayne Champion, Peter Joyner, Caroline Phegan, Sharon Frahn and Paul Worley contributed to this article.

Worthy of recognition

The four AMA(SA) members whose Queen's Birthday Honours were announced in June have brought very different skills, interests and expertise to their efforts to improve patient care.

Professor Toby Coates AO

For distinguished service to renal medicine, to professional medical organisations, and to tertiary education.

As head of the Centre for Clinical and Experimental Transplantation and past president Transplantation Society for Australia, New Zealand (TSANZ), Professor Toby Coates has a lengthy dossier of awards – including a new one as an Officer of the Order of Australia.

For Professor Coates, the main purpose of these awards is to shine a light on the work he and his team do to make life better for people with diseases that require transplants of various kinds, from kidneys and pancreas to islet cells in the treatment of hereditary diseases.

'I have more front than Myers,' Professor Coates laughs. 'Every person who makes the mistake of writing to me gets a letter back, "why don't you come to our research ball?" or "why don't you help our research?", because that's what it's all about.'

The list of research interests is also long. A conversation with Professor Coates is peppered with references to passion projects – the latest being research into hereditary pancreatitis, which affects young people aged under 20. The study has found the incidence of the rare gene in South Australia at 2.58 people per 100,000 with 40 per cent of those affected First Nations people, compared to between 0.1 and 0.3 per 100,000 in Europe.

'This is why it is so important to get it out there,' Professor Coates says. 'If you are a young Indigenous person and you turn up to the emergency department with abdominal pain, they are not going to think you have a hereditary condition. They are going to think you are a substance abuser.'

During the COVID lockdowns, he established a Rapid Response Taskforce through the Organ and Tissue Authority and Transplants Society of Australia and NZ to ensure vital organ transplants continued. Organ transplant opportunities have been lost through the loss of hospital beds, declining donations, and the difficulties in transporting organs and recipients. But the task force is dedicated to revitalising organ donation post-COVID, and vaccinating the households of immune-compromised organ recipients.

'We bring together key people in transplantation and infectious diseases around Australia to work out how we are going to respond to maintaining organ donors or maintaining shipping of organs. The question now is how we are going to vaccinate our patients and ensure we have effective immune responses. It is a huge challenge.'

As director of the Kidney Transplantation program at the Royal Adelaide Hospital, Professor Coates has also been instrumental in establishing new transplant programs, pancreatic islets and whole pancreas transplants so South Australians won't have to travel interstate for treatment. 'We now have a surgeon here to perform pancreas transplants and have set up protocols so South Australians have much greater access to this service – I'm very proud of that,' he says.

Professor Phillip Aylward AM

For significant service to medicine, and to community health administration.

When eminent cardiologist Professor Phillip Aylward began leading multicentre trials in Australia 30 years ago, they involved moving millions of pieces of paper between research centres to data centres in Europe and the US. And just as the research landscape has been dramatically transformed over the three decades since, he says, so too has clinical practice of cardiology.

Recently made a Member of the Order of Australia for service to medicine and community health administration, Professor Aylward has been instrumental in developing cardiology services and pharmaceuticals research, transforming treatments for cardiac patients – although the way he modestly explains it, he was 'in the right place at the right time'.

Since then, Professor Aylward says, there's been a dramatic change in treatment and outcomes for patients through the rise of angioplasty, stenting and primary percutaneous coronary intervention (PCI) for acute myocardial infarction, as well as drug therapies for lipid lowering and heart failure. Death rates from cardiology have dropped enormously over the same period, 'so that has really been a big success story', he says.

The expansion of cardiology services has also been dramatic since Professor Aylward first arrived at the new Flinders Hospital in 1977 as a young doctor from the UK, and, after a stint in the US, later joined the Flinders team in senior roles including Head of Division, Medicine, Cardiac Critical Care.

'I came to Flinders Uni soon after it first opened - for six months - and never looked back,' he says. 'The culture was fantastic.' Since then, he has helped develop cardiac surgery at Flinders, the private cardiology service at Ashford Hospital and Flinders Private, as well as cardiology in Darwin with significant impacts on Aboriginal health.

He was president of the SA Heart Foundation for four years and on the board of the foundation for 20 years, as well as the South Australian representative on the Cardiac Society for six years, helping promote public education about cardiac issues.

'There is a certain personality to cardiology – it's physician-ly and also procedural; It's not purely a thinking thing or pure surgery. You get the balance of connection with patients, often long term, communication but also having a procedure,' Professor Aylward says.

This enthusiasm endures, as he looks forward to the development of new treatments now on the horizon. 'There are a few frontiers – maybe genetic manipulation of people with high cholesterol for example. In development, too, are drugs to let the heart regenerate if it has been damaged – stem cell-type innovation is likely to be the next great innovation.... There's always something interesting coming along,' Professor Aylward says.

Professor Toby Coates AO

Professor Phillip Aylward AM

Dr Michael Schultz OAM

Dr Richard Willing PM OAM

Dr Michael Schultz OAM

For service to medicine as a surgeon.

There's a Facebook video of a profoundly deaf baby hearing her mother's voice after a cochlear implant. It's a scene filled with exquisite emotion.

As the founding partner of the ENT Surgeons practice, recent Head of Unit at the Women's and Children's Hospital ENT Department and senior surgeon in the paediatric cochlear implant program and hearing loss clinic, Dr Michael Schultz has been fortunate to have played a role in helping to bring about such wonderful moments.

'It's marvellous – but I do often say to people, that as the surgeon you are just the cable guy. We plug it in, and then the audiologists and the therapists do all the hard work – that's where so much of the benefit accrues,' Dr Schultz says.

Recently awarded a Medal of the Order of Australia for services to surgery, Dr Schultz has helped transformed the lives of profoundly deaf people – both children and adults – since completing his training in ENT surgery in 1995 and a fellowship in neuro-otology and skull base surgery in Cambridge.

'Implantation in a profoundly deaf child is absolutely transformational for their life,' he says. 'My understanding is that in terms of cost benefit of medical interventions, paediatric cochlear implantation is probably top of the heap in terms of how it alters a child's lifetime trajectory.'

Over the past 25 years, Dr Schultz has witnessed significant advances in outcomes for children with hearing loss, with universal neo-natal hearing screening to identify deafness at an early stage and the move toward bilateral implants for children profoundly deaf in both ears who are not helped by hearing aids.

'Bilateral implants potentially give them a lot better function in noisy environments due to improved spatial awareness of sound', when compared to single sided implantation, Dr Schultz says.

There are also a growing number of cochlear implants in older people, and emerging recognition of potential associations between severe loss of hearing and cognitive decline that may result in more active intervention to improve hearing outcomes.

'Cochlear implants in older adults can be incredibly beneficial for those people and their families and in re-engaging them with the community,' he says. 'One of the areas in which we are scratching the surface is of the linkage between hearing loss and cognitive isolation and dementia – in the longer term it may provide the impetus for us to optimise hearing in older people.'

Dr Schultz's contribution to the profession also includes a keen interest in training a new generation of surgeons. He is past Chairman of the State Ear Nose and Throat (ENT) Training Committee and recently completed a 9-year term as Examiner in ENT Surgery, Royal Australasian College of Surgeons. Having stepped away from these roles, he is looking forward to re-establishing regular examination preparation sessions for the state's ENT trainees, something he very much enjoyed in previous years.

Dr Richard Willing PM OAM

For service to conservation and the environment

There are not many people who can tick off a bucket list that includes graduating as a doctor, working in Antarctica, undertaking postgraduate training in the UK in a dynamic and expanding specialty, and advancing ecological conservation.

Yet for gastroenterologist Dr Richard Willing, it would appear that a recent Queen's Birthday honour for services to conservation and the environment is evidence of what can be achieved when motivation is strong.

As a small boy, Dr Willing formed a firm intention to become a doctor and won a Commonwealth Scholarship to pursue his ambition. He became a general practitioner, lacking the funds to continue in his chosen field, gastroenterology, where innovation beaconed with the introduction of fibre-optic cameras into the gastrointestinal tract.

When he saw an advertisement for a medical officer posting at Mawson Base in Antarctica during the International Geophysical expedition of 1957, he jumped at the chance to chase another dream.

'Ever since I was a small boy it had been on my bucket list to do something in Antarctica. I'd grown up on the great stories of heroic exploration of Shackleton, Scott and Mawson,' he says.

Liberated by the lack of medical emergencies, Dr Willing was able to participate in environmental research, spending the winter researching emperor penguins and the summer on a seismic survey about 950 km from the base.

'The Antarctic Division was still very young and still finding its way, and our equipment was not the best – there were a lot of times when we were more uncomfortable than the people down there now would be,' Dr Willing says.

He returned from an icy frontier to a scorching one, working at the Woomera rocket launching range to save enough for postgraduate study in the UK with his young family. He returned to senior clinical roles at the Royal Adelaide and Modbury hospitals and Flinders Medical Centre, particularly relishing the teaching aspects and the exchange of ideas. He was engaged in a number of associations including AMA(SA), where he was secretary for a number of years, helping smooth the kinks during the introduction of Medicare and providing advice in medical misconduct cases.

At the same time, he counterbalanced the professional life farming cattle and sheep on a farm south of Adelaide, where he introduced sustainable grazing methods with rotational grazing.

Unlike many contemporaries, Dr Willing was convinced of the need to conserve the scrubland and formed a Heritage Agreement to preserve it. Twice a year for more than 20 years, he has undertaken biodiversity surveys of the scrub, trapping, weighing and microchipping small mammals to collect a wealth of longitudinal data.

'Our policy was to retain as much scrubland as possible instead of flattening it all. A lot of people still think we are nuts, but it doesn't worry me,' he laughs. 'The interest in nature and ecology has been a constant theme – it's been a big part of my life.'

A dire diagnosis

Professor Chris Baggoley has survived a diagnosis of pancreatic cancer. But he says survival shouldn't be a matter of a lucky diagnosis.

It wasn't the news he wanted to hear.

Former Australian Chief Medical Officer and long-time South Australian emergency physician Professor Chris Baggoley personally knew 10 people who had been diagnosed with pancreatic cancer when he was diagnosed in January 2019. Of the 10, only one is living.

Professor Baggoley knew that while there are about 4,000 pancreatic cancer diagnoses in Australia each year, the proportion that lead to death is higher than for breast cancer and prostate cancer. That pancreatic cancer is Australia's third deadliest cancer behind lung cancer and bowel cancer, killing over 3,300 Australians a year. That the five-year survival rate is about 10 per cent.

So, Professor Baggoley knows he is extremely fortunate. First, his GP sought blood tests due to weight loss and blood sugar anomalies that could have been caused by any number of conditions. Then, a CT scan found a cyst, and then an MRI found the cancer next to the benign cyst.

Now, after complex Whipple surgery – which removed half of his pancreas, his gall bladder and parts of his stomach and liver – and six months of chemotherapy, he's recovering, gaining weight and exercising again. And, having retired from fulltime medical roles, he's added PanKind – the Australian Pancreatic Cancer Foundation – to the list of organisations to which he offers his time and expertise as an advisor or board director.

PanKind has recently launched the PanKind Early Detection Initiative, working with the research community to improve early diagnosis of pancreatic cancer. The Early Detection Initiative has funded two new research projects aimed at increasing the proportion of patients diagnosed with operable disease through early detection, looking to triple survival rates by 2030.

The Australian-led project with the QIMR Berghofer Medical Research Institute involves more than 13 groups of scientists, clinicians and policymakers in Australia, New Zealand and the US. Professor Rachel Neale of the institute's Cancer Aetiology and Prevention Laboratory says the goal is to identify who is most at risk of pancreatic cancer and to determine whether monitoring this group would lead to better outcomes. Her team will link the national data of thousands of patients who had pancreatic cancer over the last 15 years and use machine-learning methods to predict people's risk of pancreatic cancer.

The second project, led by Associate Professor Andrew Metz at the Jreissati Family Pancreatic Centre at Epworth, will examine the specific factors that lead to a diagnosis of pancreatic cancer among people with late onset diabetes, ideally leading to a cost-effective screening test.

'Both are looking at if there are factors or a combination of factors that can signal pancreatic cancer – particularly a diagnosis of diabetes and whether there's a link there,' says Professor Baggoley, who is now deputy chair of the PanKind Board and chair of its clinical advisory panel.

He points to recent news of a British National Health Service (NHS) trial of a blood test that may be able to detect more than 50 types of cancer.

As reported in the journal *Annals of Oncology*, the NHS will this year begin a trial involving 140,000 people that if successful could help millions of patients by 2025. The paper reported that the test by Californian company Grail can accurately detect cancer, including in people without symptoms; had a false positive rate of 0.5 per cent; and predicted the cancer's location.

The test detected 65.6 per cent of cancers involving solid tumours with no screening options, such as oesophageal, liver and pancreatic cancers. For those where screening is possible, including breast, bowel, cervical and prostate cancers, the figure was 33.7 per cent.

Professor Baggoley said that if successful, the blood test could be added to doctors' diagnostic tools within two years, instead of the five or more years required to approve a new drug. Similarly, if the Epworth research shows there is a link between diabetes and pancreatic cancer, doctors who see those symptoms may consider pancreatic cancer as the reason and diagnose it faster.

Professor Chris Baggoley with Millie at home in 2020

Professor Baggoley pointed to a new reference guide to make GPs more aware of pancreatic cancer symptoms and investigation steps. Published in June 2021, the Cancer Australia and Cancer Council Optimal Care Pathway for pancreatic cancer and a four-page quick reference guide are available on the Cancer Council website.

Early detection the difference

On Tuesday, 7 May 2019, Craig Atkinson was 52 years old, a non-smoker who ate well, strong and fit and healthy – or so he thought.

However, he had experienced ongoing and unexplained back pain for only a short period of time. He started to experience indigestion symptoms which his GP had attributed it to the anti-inflammatories he was taking for the pain. He and his partner, Jodie Atkinson, had sought a second opinion – and it was on 7 May that this second GP called with the results of a CT scan.

Mr Atkinson had been diagnosed with inoperable pancreatic cancer.

Mrs Atkinson says the couple chose a course of treatment that could give him six - eight months, instead of the three to six months he might have if he opted for no treatment. But within two weeks he could hardly stand. He died 37 days after the CT scan.

'We'd barely got used to the fact that he was sick before he died,' says Mrs Atkinson, who is now a volunteer spokesperson for PanKind. 'Pancreatic cancer is such a silent, aggressive cancer. There are so many people who find themselves in our situation.'

Mrs Atkinson has applauded the introduction of new information for doctors to help them consider pancreatic cancer as the cause of a range of symptoms, and the funding of new research into pancreatic cancer and its links to diabetes.

'If we had known back pain was a symptom, we could have considered cancer as the cause. We may have had more time – more options,' Mrs Atkinson says.

The Walkley Heights resident says she knows two women whose partners went to the doctor with back pain and were later diagnosed with inoperable pancreatic cancer, and she has read of more cases since. 'If this is a possible symptom, or there are others presenting with back pain, it would be wonderful to make doctors aware,' she says. 'Early detection could be the difference between weeks and months, or even survival.'

The heart of the matter

Cardiologist Dr Alistair Begg says fast-moving innovations in many aspects of treatment are improving care and outcomes for cardiac patients.

Cardiologist Dr Alistair Begg

There was a time not too long ago when treatment for a heart problem was like a major plumbing job: it required major excavation.

Fast forward to today and innovation in cardiology means procedures such as aortic valve replacement, which used to require open heart surgery, can be achieved through an incision in the groin.

'Cardiology is less and less invasive these days. A lot of the angiograms are done non-invasively. We don't have to stick tubes into people's hearts – it's just a needle in the arm,' says SA Heart cardiologist Dr Alistair Begg. 'The advent of these types of treatments means less hardship for patients, and tests that are less invasive, have less risk, and are more comfortable.'

Just as the world has been transformed by digital technology, so has cardiology. Remote monitoring of pacemakers has become just part of the package, allowing patients to have their heart rhythms downloaded to a central database, with the cardiologist alerted via email if there is a problem.

'People in nursing homes don't need to come in any more for routine check-ups – we just download the information from their pacemakers. That's an example of where the use of available technology has made a big difference to patients,' Dr Begg explains.

'The other thing that is exciting is monoclonal antibodies such as Repatha, which is a new treatment for lowering cholesterol.'

New cholesterol treatments have fewer side-effects and are better tolerated, Dr Begg says.

Equally, he says, advances in medication – including diabetes drugs such as Sodium-Glucose Co-transporter-2 (SGLT2) inhibitors, which act on the kidneys to excrete excess glucose – are very effective at preventing heart failure.

'We are moving towards earlier detection of disease,' Dr Begg says. 'Once upon a time, people would come in with a heart attack and we'd run down and put a stent in them or give them clot-busting drugs – now they come in with a few symptoms, and do a few tests and we work out if they have a heart problem. We can pick it up early and prevent it.'

He says the profession has become 'pretty good at the plumbing side', with innovations such as stents. Now, there is a focus on the 'electricals'.

'There are more and more electrical specialists coming through, and new things like small recorders that you can slip under the skin and monitor for arrythmias,' he says.

The outlook is exciting, with one example the potential use of stem cells to repair heart cells.

'It's been promising for quite a few years – there's potential but still several hurdles in terms of how it is going to work,' Dr Begg says. 'The new cells must be beating at the same time as the rest of the heart.

'There's a lot of research, but clinically it's not quite there yet,' Dr Begg says. 'Many factors have to be resolved before it is singing and working well. New cells may not grow in scar tissue, for example.'

Concerningly though, research such as that from the University of Melbourne (Lopez and Adair, 2019) is finding that cardiovascular disease mortality rates have almost stopped declining in many high-income countries, including Australia.

One contributing factor is COVID lockdowns. US data suggests patients presenting with symptoms later than they would normally is likely to have led to cardiac patient mortalities in this country. However, Dr Begg says Australia has been fortunate not to see the cardiac complications of COVID such as myocarditis which have been identified in countries with higher incidence of COVID.

Increasingly, he says, arrythmias are the reason for cardiac-related emergency department admissions, replacing heart attacks as the cause in the 1980s, and heart failure, which prevailed in the early 2000s. 'If you look at years lost due to cardiology, there are probably fewer than through childhood cancers and other things – it's still a killer but not so much of young people,' Dr Begg says.

'Arrhythmias are at almost epidemic proportions now – they tend to occur in people with risk factors like being overweight, drink too much or don't exercise, or when they get old and have survived a bypass for 30 years.'

Fortunately, he says, Adelaide is home to one of the world's leading experts in atrial fibrillation, Professor Prash Sanders, who Dr Begg says 'looks at models of care as well as procedures'.

'Considering we are a small state, we have great institutions that are well known around Australia and the world,' Dr Begg says. 'If you go to a conference in Switzerland, they all know about Adelaide and know half the professors in Adelaide.

'In South Australia we bat above our weight – in terms of our population size we have a lot of very good clinicians and researchers, although it is difficult to keep them here.'

Creation of the biomedical precinct and the South Australian Health and Medical Research Institute (SAHMRI), investment in biotech, and the city's liveability will all help retain talent, he says.

Doctors join UNICEF to boost vaccine supplies

Doctors are being urged to ask their patients being vaccinated against COVID-19 to donate towards vaccinating people in developing countries, in a 'pay it forward' scheme designed to quench the virus around the world.

The Immunisation Coalition Scientific Advisory Committee is supporting a program by UNICEF Australia to enable people in developing countries more access to the COVID-19 vaccines.

Immunisation Coalition Chair Dr Rod Pearce warned the virus, which has killed about 3.9 million people to date, will continue to mutate and spread unless all populations are fully vaccinated.

'We're supporting UNICEF's program, where $5 will allow one person to become vaccinated with two doses of vaccine against COVID,' Dr Pearce says.

'We hope it reminds people that we can vaccinate ourselves and protect Australia, but we can also make some contribution to what's happening overseas and meet the challenge to vaccinate everyone.

'This campaign is about reminding us of our obligation, and broader reflection about our responsibilities to our bigger community.'

UNICEF has said a focus on vaccine supply and demand is needed, including additional funding to promote vaccine demand through building capacity and systems and tools rooted in behavioural science.

Immunisation Coalition member Associate Professor John Litt says that while many of those living in high-income countries can now access free COVID-19 vaccinations, many lower-income countries are yet to receive a single dose.

Developed countries, representing only 14 per cent of the world's population, have secured more than half the available doses of vaccine, while less than 5 per cent of the population in the low-income countries with two-thirds of the world's population have been vaccinated. The Global Commission of Post Pandemic Response has estimated that 22.6 per cent of the world's population has received at least one dose of the vaccine and around 2.8 billion doses have been administered globally – although comparatively few in low-income countries.

Assoc Prof Litt says five billion doses are needed to ensure the virus is controlled globally.

Herd immunity will remain a pipe dream unless developing countries are vaccinated, UNICEF has warned.

Every $5 donated to UNICEF Australia's scheme will provide one person with two doses of a COVID-19 vaccination in a low-income country and giving $200 could protect 40 people in a developing country, UNICEF says. To learn more and donate, go to the UNICEF Australia website.

Council news

Dr Shriram Nath
Pathology Representative, AMA(SA) Council
AMA(SA) Council Meeting, August 2021

COVID-19 continues to bring changes to how we doctors perform our duties. At Council, we are now using the QR code. Masks were in place. Some members joined us via Zoom, although Vice President Dr John Williams again took the trip from Port Lincoln to join us in person.

Professor Peter Subramaniam demonstrated he is bringing his personal style as Chair, from the start of his second meeting in the role, reminding us of the objectives of the AMA. Immediate Past President and Federal Vice President Dr Chris Moy gave an update on the COVID-19 Delta variant. He said mixed messaging continues to affect vaccination rates. Councillors expressed concerns about the effect of COVID-19 cases on bed numbers, especially negative pressure ICU beds in South Australia, and the challenge of easing ramping at already overworked emergency departments with non-COVID-19 patients. The South Australian population's constant use of QR-code check-ins, which has helped contact tracing and combating the pandemic, was applauded.

Discussion turned to the new Women's and Children Hospital and the initial plan that has been unveiled. Councillors queried whether air bridges to the RAH may lead to downsizing of clinical departments such as pathology and gynecology, or amalgamating the units with those at the RAH, as cost-cutting measures. Will training positions be lost? It was agreed that the next phase of planning and designing the interior of the building is crucial. Lessons learnt from the RAH experience must be applied; 'meaningful' clinical consultation is essential.

President Dr Michelle Atchison and other Councillors noted that mental health is in a state of perpetual crisis in South Australia. It seems to be a revolving door for patients to be admitted, stabilised, discharged and readmitted. The system is failing the patient. How long will (or should) South Australians be 'patient'?

The Doctors in Training brought some light to the meeting. Their enthusiasm for combating climate change in the health sector and working on a sustainability principle for the AMA(SA) was welcomed. They also noted that financial hardship and cohort diversity are real issues among junior doctors. More needs to be done by the Colleges to address the issues.

Medical history a shared passion


Dr Ian Roberts-Thomson

A common interest in medical history is bringing doctors together.

Are you interested in the medical heritage of South Australia? For medical practitioners keen to maintain a link with colleagues, one option is membership of the South Australian Medical Heritage Society (SAMHS). The Society was established in 1984 to promote the history of health and medicine in South Australia and to establish a medical health museum. Several years ago, a decision was made to develop a website that includes information on prominent medical or other health practitioners, and topics of historical interest in South Australia. The website at www.samhs.org.au also contains a virtual museum of items largely held in collections in South Australia, and details of previous and future meetings.

The major activity of SAMHS is the monthly meeting in the Royal Society rooms behind the Adelaide Museum, with a talk, often by a medical practitioner or historian, on some aspect of medical or health history involving local, national or international themes. These talks last for about 40 minutes and are followed by questions from the audience. Social interaction is encouraged by mingling over 'drinks and nibbles', although this has been restricted over the past 18 months because of COVID-19. The history of the evolution of medicine in South Australia is populated by some fascinating stories and colourful personalities and we have been fortunate in the quality of our speakers. These include senior medical and dental practitioners and historians, the Chief Scientist for South Australia, and occasionally visitors from interstate and overseas. Attendance as a member or guest is open to any interested person.

In 'normal' times, activities have also included excursions to museums such as those associated with the Central Adelaide Local Health Network (CALHN), Kapunda Museum, Torrens Island Quarantine Station and St John's SA.

SAMHS is one of at least three groups in Adelaide with a strong interest in medical history. Others include an historical group associated with AMA(SA), and the CALHN Hampstead Museum. The groups now work co-operatively to promote health and medical history, but SAMHS is the only community group with 'members and friends' and regular meetings.

Adelaide has also been chosen as the location for the national conference of the Australian and New Zealand Society of the History of Medicine in 2023, with the SAMHS President as convenor.

Dr Ian Roberts-Thomson, President, SA Medical Heritage Society

Student news

Sam Paull
President
Flinders Medical Students' Society

As we move into the second half of the academic year, I thought it would be a good to provide an update on the Flinders medical program. While we were fortunate during semester one to have a largely uninterrupted university experience, the recent lockdown in South Australia and the ongoing issues faced by the eastern states is a good reminder of how quickly things can change.

The university and particularly the College of Medicine and Public Health have become significantly more agile in their ability to provide education in both face-to-face and online settings. Evidence of this was provided in the most recent lockdown, when the year 1 and 2 cohorts had all their content moved online so they could continue their learning without significant interruption. Unfortunately, the pre-clinical cohorts are still unable to visit the wards due to the understandable restrictions. The Flinders Medical Students' Society (FMSS) is working closely with the College to try and mitigate the impact of this lack of face-to-face clinical experience with real patients and ward teams before the students progress into their clinical years.

The clinical year cohorts were fortunate to be counted as 'essential' and so were able to continue attending placements throughout the lockdown period. This reflects recognition of the clinical year students as being part of the teams within the hospitals, and helps prepare them for life as junior doctors when a pandemic may be par for the course. The students are appreciative that the Local Health Networks and SA Health have enabled them to continue with placements and have a relatively uninterrupted learning experience.

Students across all year levels have also been taking advantage of having access to COVID-19 vaccinations, and I am pleased to say that most of the cohort are fully vaccinated. It is important for us as medical students to contribute to the important public health messaging around vaccination, especially as it is the under 50s group that displays the greatest rates of vaccine hesitancy: the recent *Taking the Pulse of the Nation* survey showed that 19 per cent of people under 50 in Australia are unsure of whether to get vaccinated (and more concerningly 20 per cent are unwilling to be vaccinated).

On the social front, FMSS is remaining cautiously optimistic that we will be able to conduct our events, albeit with restrictions in place. Our annual Med Ball is scheduled for the end of August and, if we can hold it, will provide a great chance for students to relax and socialise. FMSS is also planning a number of sporting events, with a restarting of the MD1 versus MD2 sports events after a one-year hiatus, as well as continuing our friendly rivalry with Adelaide Uni in the FMSS v AMSS sports day.

Preparations for the annual Med Review are also progressing well and I am looking forward to seeing the creative acting and musical talents of my fellow students on display. I encourage you to come along if you're lucky enough to snag a ticket. Hopefully we will be able to go ahead with all our plans for the rest of the year, but – much like the university (and the rest of the country) – we must remain agile and adaptable, skills that will no doubt serve us well as we transition into junior doctors.

Patrick Kennewell
President
Adelaide Medical Students' Society

As students get back into the swing of semester two, the Adelaide Medical Students' Society (AMSS) kicks off with a big calendar of events for August and September, including Health and Wellbeing Week featuring yoga, cooking classes, a workshop on sexual health and care packages for our clinical students at different sites across the state. Our sports officers have planned dodgeball against the dental students and lawn bowls against the engineering students, and we are looking forward to some fierce rivalry in these competitions.

We are proud to announce a new blood drive initiative, in collaboration with the Law and Engineering Student Societies, which we hope will increase donation rates among university students. Other events just around the corner include our Back to the Suture themed pubcrawl, the Medball and our annual Medrevue, which will see a talented cast put their spin on Shrek.

On the advocacy front, we are pleased to have ongoing open discussions with the Australian Medical Council and South Australian Medical Education and Training (SAMET) bodies about the implications of the National Framework for Prevocational Training for graduates in South Australia. We are looking forward to having SAMET speak to the AMSS Committee on these changes. This has been very timely, with sixth-year students having received their internship offers for 2022. They are making the most of their remaining time as students before they start working next year.

The AMSS continues to advocate against the change from non-graded passes to an M10 (pass, credit and distinction model) under the MD program starting next year. We are pleased to have support from the faculty to raise our concerns and work together to create the best possible program for students.

Another win for the AMSS was in gaining students prompt access to COVID-19 vaccinations. A big thank you to the Central Adelaide Local Health Network and SA Health for ensuring students were able to access vaccinations through walk-in appointments at the vaccination hubs. Following a meeting with AMA(SA) President Dr Michelle Atchison and CEO Dr Samantha Mead, the AMSS will now meet quarterly with the AMA so we can seek advice and collaborate on our advocacy.

Finally, the AMSS would like to extend our gratitude and commiserations to all the students who put in a huge number of hours towards AMSA's convention, which was scheduled to be in Adelaide this year but unfortunately was cancelled due to pandemic restrictions. However, the online academic program turned out to be a real success. I'd like to extend a special thanks to the core team of Florencia Moraga, Huy Pham, Nathan Dignam, Don Kieu and Jayda Jung, who spent two years working towards the event.

AMSA President Sophie Keen

'Trapped in a system that failed them'

Australian Medical Students' Society President Sophie Keen provided a blunt assessment of the impacts of impacts of a fractured health system on doctors' mental health at the AMA National Conference.

This is an excerpt.

'I have the great privilege of representing Australia's 17,000 medical students and voicing the priorities and concerns of our emerging health workforce.

Even as a student, the AMA has been a consistent source of support and guidance. The AMA stands as one of AMSA's biggest advocates and allies, and the health and wellbeing of Australia's medical students continues to be a shared priority. The advocacy that I've seen from this organisation during COVID has been remarkable and tireless, and the membership should be incredibly proud.

I didn't always have an interest in medicine. I had a pretty rough relationship with my mental health growing up and had experienced a fractured and frustrating healthcare system. However, like most here, I had a vague desire to 'help people', and this seemed a sure enough way to get there. My parents, while very supportive, knew I had chosen a difficult path for myself, and were eager to shield me from the stressors of a life in medicine. One day my mother pleaded with me to reconsider and offered to move together to a small island where we could build a self-sustainable farm.

Fortunately, I've loved medicine and I only dream of my could-be farm during exam seasons, but unsurprisingly, my parents had shown a degree of insight that I had probably lacked. I was balancing my degree with part-time work and multiple advocacy roles, and it wasn't long before I developed generalised anxiety. It was 2017, and a lot of the dialogue in the medical student and doctor mental health space was centred on mandatory reporting.

Only a few years prior, BeyondBlue had released a report on the unintended consequences of mandatory reporting requirements, citing that one in three doctors saw the potential impact on registration, right to practice, and career progression as a barrier to seeking help for depression and anxiety. Like many, I was left confused and overwhelmed, convinced that disclosing my experience could threaten my career. Things got worse and eventually I did see a GP. When I inquired with them about mandatory reporting, they confessed they didn't quite understand the legislation either. They weren't sure if my anxiety constituted an 'impairment', if it would impact my registration at the time of graduation, or if I would be added to a proverbial 'no fly' list. I was so frightened that I left the consultation room as quickly as possible, and I didn't seek care again for many years.

It was only once my anxiety became pretty unbearable that I ventured back to my GP. By this time, I'd started having panic attacks. I'd lose my appetite and stop eating for days on end, and I'd drive to placement only to burst into tears in the carpark. I'm the first to admit that my experience was a lot milder than many others, and I'm grateful now to have learnt far more productive coping strategies than a good car-park sob.

However, so much of this was avoidable. My access to care was frustrated by stigma and uncertainty, driven by policies that lacked transparency and systems that failed to protect vulnerable people. In front of me was a key lesson that our policies and systems impact real lives, and with three quarters of doctors reporting feeling anxious or depressed, the potential for harm is significant. Mental health awareness has entered the cultural zeitgeist over the past decade. Athletes, celebrities, politicians and companies are all celebrated for public and progressive approaches to wellbeing. While I applaud this effort, we are still losing the battle. In the first six months of this year we have lost three medical students to suicide. I did not know them, so I cannot tell you their stories – but I promise you they each had one.

What I can say is that they found themselves trapped in a system that failed them. We're left with holes in communities, in workplaces and in families that will never truly heal. The often-quoted BeyondBlue survey of medical student and doctor mental health reported suicidal ideation in about a quarter of doctors. That is a quarter of your clinical team, a quarter of your college, and a quarter of the people here today. Even worse is our suicide rate, which for male physicians sits about 40 per cent higher than the general population, and for female physicians is 130 per cent that of our non-medical counterparts.

This profession gives people the knowledge and the means to make highly lethal decisions in times of crisis. It then serves up psychological distress on a silver platter of long working hours, significant responsibility, poor work-life balance, and interpersonal and clinical challenges. Meanwhile, our workplaces fail to provide basic structural supports needed to protect those with the least power. If your health system has doctors working unpaid overtime, if unaccredited registrars are struggling in hostile conditions, if there is racism, bullying and sexual harassment swept under the rug, then the system is failing us and, by extension, we are failing each other.

As people with power, we have an obligation to push forward solutions to these problems, because the cost of complacency is measured in lives. From calling out inappropriate comments in the workplace, to giving your juniors guilt-free permission to leave on time, and from properly gendering all of your patients, to making your practice culturally safe, you will slowly but surely lead by example, and your actions will define our norms. Cultural and social change happens slowly, but there is no more important priority. I hope that you will help me. Thank you.'

Sophie Keen is a medical student from Campbelltown in Western Sydney.

Waste not, want not

Healthcare organisations must identify the issues at the heart of their problems before designing a solution to fix them, writes author Associate Professor Douglas Fahlbusch.

Adelaide anaesthetist A/Prof. Douglas Fahlbusch, MBBS, FANZCA, GDM, GAICD writes and speaks about healthcare and system innovation. He analyses problems from the perspective of patients, healthcare workers and management. Further reading can be found in Reimagining Healthcare: how administrators and conditions reduce risk, waste and disjointed services. He can be contacted at admin@douglasfahlbusch.com or through his website, www.douglasfahlbusch.com.

The problems and challenges faced by most healthcare organisations are remarkably similar and are found worldwide, as uncovered in Mark Britnell's *In Search of the Perfect Health System*. They stem from an industry undergoing widespread change, enabled by technology, and driven by the individual expectations of patients, staff and doctors. In the short term we are being forced to cope with the unpredictability of COVID-19. In the medium term we are experiencing chronic budgetary constraints - and seeing a shift from episodic, reactive treatment of disease to large scale, proactive optimisation of health.

This puts the healthcare system under strain. Patients, staff and doctors suffer, as evidenced by the epidemic of burnout and mental health issues across society. As BeyondBlue's 2018 survey of doctors' and medical students' mental health found, clinical personnel have rates of burnout at two to three times those of the general population or other professionals with similar responsibility. Burnout, characterised by a loss of enthusiasm for work and depersonalisation, leads to reduced effort with implications for errors and a loss of productivity.

However, most failure is a result of the system rather than people. My daily experience in the healthcare setting is of healthcare personnel compensating for the system's shortcomings. Shortcomings include duplication of effort, delays and other forms of what the OECD in its 2017 *Tackling Wasteful Spending on Health* report estimated as a 20 per cent waste in healthcare spending worldwide. This represents $40 billion a year in Australia! We are usually so busy 'doing' that we are unable to devote sufficient time and effort to thinking about 'how' we do.

Without coordinated improvement measures, both human and financial capital are wasted. If we are to reconfigure health care, what aspects are most important to redesign? Four categories can be considered.

Operational issues – these tend to dominate people's daily work, and include:

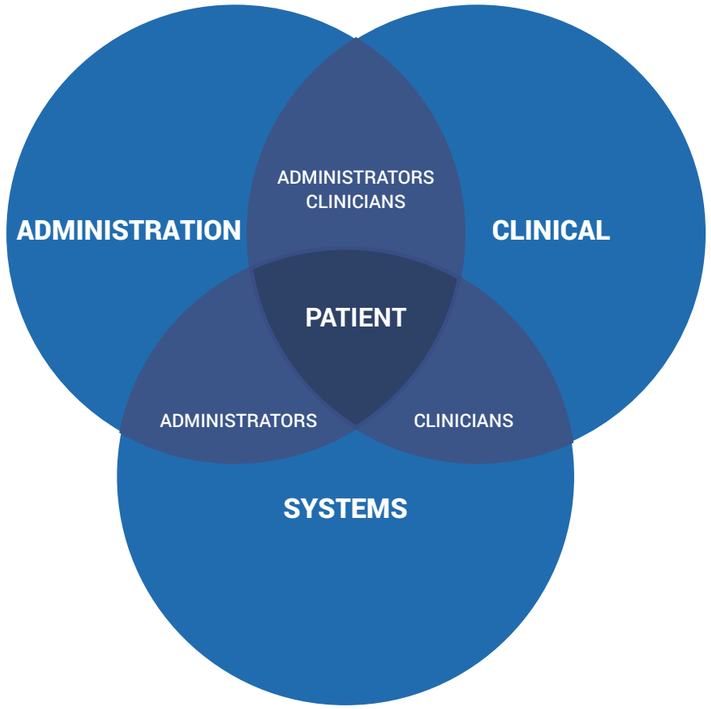
- ensuring appropriate resourcing for routine and unexpected requirements in the face of increased patient and treatment complexities, including COVID-19
- reducing resource and energy usage
- security of information, people and equipment
- 'leapfrog' developments such as moving from paper to computerised systems, or adding a new department
- optimising bilateral executive-employee communication to avoid information loss, whether translating a vision into daily tasks, or feeding back problems from daily tasks.

> ***Sub-optimal care is the third highest cause of death in developed healthcare systems – and system problems, rather than mistakes, are the highest contributors.***
>
> ***Martin Makary, MD MPH***

People issues – these relate to everyone involved, such as support and administration employees, nursing/allied and clinician employees, patients, and visiting clinical staff. Aspects include:

- attracting and retaining top-quality people
- identifying, training and/or removing problematic personnel
- managing 'presentee-ism' – pleasant underperformance – to promote engagement and efficiency

Redesign Interactions



- reducing the use of 'temporary' staff, which often comes with higher costs and reduced efficiency
- collaboration –ensuring that the healthcare experience meets patient, carer, staff and clinician expectations.

Financial issues – these exert pressure on decision-making, which can lead to decisions that are detrimental to healthcare as a whole. Considerations include:

- payroll costs – a healthcare enterprise's major outlay
- clinical variances and cost outliers – where treatments and/or clinicians' costs exceed benchmarks
- a reduction in revenue streams from macro-economic pressures, competition and fewer customers having private health insurance
- pricing/cost transparency, particularly for medications, devices and insurances
- reducing margins.

Strategic issues – these tend to be drowned by day-to-day operations. Healthcare has a culture of 'putting out fires'. Factors include:

- modernisation – ways to consistently assess the next 'big thing', whether it is equipment, medications, operations, technology, or new healthcare delivery models
- competition from similar or alternative healthcare providers
- governance – meeting external compliance requirements alongside continuous regulatory/ legislative change; in particular, security of data
- risk – improving the safety/quality culture to reduce business and clinical errors
- creating value for society, patients, clinical personnel and administrators.

So, where do we start? Unfortunately, there is no one-size-fits-all answer. As Harvard Professor of Medicine Dr Lewis A Lipsitz has pointed out in his paper, *Understanding health care as a complex system: the foundation of unintended consequences*, different organisations have different priorities within the complex and adaptive system that is healthcare.

However, consideration of the prompts above will highlight for any organisation or business/clinical unit at least two or three directly relevant major concerns.

When major issues for both senior management and frontline healthcare workers are inter-related, the likelihood of a successful improvement increases. A major issue for management will be difficult to improve if it does not benefit front-line staff in some way. Similarly, a major issue for healthcare workers will be difficult to improve if management does not see or understand the benefit to the organisation.

Clinicians often sit in both executive seats and on the front-line, and so have an important role in reconciling these apparently competing demands. Issues at first glance often appear unrelated, especially to those focussed exclusively on their roles. Applying a systems approach to desired improvements, as depicted in the figure, helps to uncover associations – and importantly helps to avoid unintended negative consequences of an intervention.

Considering the whole system often leads to a change in priorities for redesign, resulting in an increased likelihood of success. For example, transitions of care between staff or healthcare facilities cause a loss of continuity and impair the healthcare experience for workers and patients. As much as half of the handover information is distorted or missed. Ensuring technological, financial and legislative support for transitions of care is one way of both supporting and improving all facets of a patient's health and care.

Recognising that the patient and the patient's data are the only constants within the care continuum helps us design care pathways that work for patients, healthcare workers and administrators. It also helps to reconcile the competing demands of local, state and federal healthcare. Anchoring healthcare to the constant of the patient and their data enables us to design a resilient yet adaptable healthcare system that can tackle the threats that we face.

FURTHER READING

i. BeyondBlue. *National Mental Health Survey of Doctors and Medical Students*. 2018

ii. Britnell, M. *In Search of the Perfect Health System*. 2015: Palgrave Macmillan. Kindle Edition.

iii. OECD. *Tackling Wasteful Spending on Health*. 2017; Available from: https://www.oecd.org/els/health-systems/Tackling-Wasteful-Spending-on-Health-Highlights-revised.pdf.

Responding to those in need

From left: Dr Kamban Babu, Dr Neeraj Gupta, Dr Tushar Singh, Dr Seshu Boda, Ms Reeba Mathew, Dr Shriram Nath, Professor Nicola Spurrier, Dr Rajeev Mahajan, Dr Preetam Ganu Dr Jaiveer Krishnan

Back from left: Mr Norman Schueler, Mrs Carol Schueler, Health and Wellbeing Minister Stephen Wade, Dr David Spurrier, Dr Seshu Boda, Dr Radhika Dara

Front from left – Dr Martin Bruening, Mrs Julianne Bruening, Mr Chris Picton MP, Professor Nicola Spurrier

The South Australian Indian Medical Association (SAIMA) has played an effective role in managing the ongoing COVID-19 crisis in the South Australian context, says SAIMA President Dr Seshu Boda.

Dr Boda says SAIMA aims to provide a common platform for health professionals, including from allied health and nursing, interested in the Indian subcontinent.

He says that in early 2020, SAIMA and its dedicated members responded to the request from SA Health and provided their support and time to look after the first two full flights of almost 700 returning Indian Australians.

'Many of the SAIMA members are an ongoing part of the SA Health frontline workforce, whose dedication and skills are making a huge difference in management of the pandemic,' Dr Boda says.

'Our partnership with UNICEF has raised nearly $40,000 towards efforts to fight COVID in India.'

The SAIMA Annual Charity Gala Dinner was held at the Adelaide Convention Centre on 19 June 2021. South Australia's Chief Public Health Officer Professor Nicola Spurrier was the keynote speaker at the sold-out event, which had as its theme 'Women in Health'.

Attendees included Health and Wellbeing Minister Stephen Wade, Shadow Health Minister Chris Picton, members of other associations, past presidents, doctors in training, medical students, families, and corporate supporters.

Dr Pat Richter at her graduation

Calm under pressure

Dr Pat Richter

16 June 1930 - 1 June 2021

When Dr Pat Richter joined the Stirling General Practice with Drs Peter Brummitt and Hugh Dinnick in 1974 she became the first female general practitioner in the Adelaide Hills and began what she later described as her happiest working years.

Upon retiring in 2000, Pat said the move had allowed her to follow her interest in women's health and aged care and she became a well-loved member of the community.

It was a long way from the Northumbrian Hill Farm in the UK where the young Pat Stephenson (definitely not Patricia!) spent her early years with her parents John and Minnie Stephenson, older sister Kath and younger brother John. She recalled spending beautiful summers playing in the hayfield, and battling heavy snow to travel to school by horse-drawn sleigh, before moving with the family to a larger village with a better equipped school when Pat was seven.

She later found work cleaning jars in the medical school at Newcastle University, where a mentor encouraged her to apply for the school of medicine. She was accepted into the Medical School at Newcastle in 1948, where there was a 20 per cent quota for school leavers and most entrants were ex-service men and women.

Training standards were high. The school had a reputation for being forward thinking as paediatrician Professor James Spence took the unusual step of encouraging mothers of young children to stay with their sick children in a purpose-built hospital.

After graduating, Pat worked in hospitals for two years before starting in general practice, working in industrial South Shields before, desperate to escape the thick black smoke for a moment, she embarked on a working holiday, doing obstetrics in Singapore where her sister and brother-in-law were living.

She almost returned to England but was persuaded to join a crew of five on a dream journey by soft ketch to Australia. She was invited for her medical skills (which she fortunately did not have to use) but worked hard as a crew member – especially given the only experienced sailor and navigator was the owner-captain, an ex-merchant navy captain.

She described an epic journey, travelling from Singapore to Sarawak, Brunei and Sandakan which had been badly damaged in the Pacific War. The journey, though punctuated with wonderful sunrises and sunsets, clear star-filled night skies and crystal-clear waters with turtles and fish, was a battle against the elements.

After a brief stint in Darwin and Thursday Island, Pat took up a post as Casualty Officer at Canberra Community Hospital. She fell in love with Australia and was determined to stay. Yet fate intervened momentarily, sending her back to the UK during a family illness in 1948 and she met Paul Richter, her future husband, a Swiss national.

They exchanged love letters between the UK and Switzerland and returned to Australia together, marrying in June 1959 and setting up house in West Croydon, Adelaide.

Paul became the Swiss Consul in Adelaide and Pat was among the vanguard of working mothers, working at the Adelaide Chest Clinic and the Adelaide Children's Hospital while caring for children Pia and Michael. And like many children of working mothers in the day, Pia remembers being taken to work, visiting young Aboriginal patients at Escort House at West Beach.

Pat was famous for her generosity, good humour and hospitality, making their various homes beacons for visitors. Summers were spent with friends on the beach at Chilton Rocks and Middleton. Refusing to be typecast, the sea adventurer and career woman was also a cosy fireside person, loving cooking, knitting, reading and gardening.

Her family marvelled at her incredible capacity to be calm under pressure (perhaps galvanised by that fateful sea journey). Her mettle was tested on a family holiday to Switzerland where she drove the family in a minibus through hair-raising roads with steep drops in Switzerland, calmly pointing out the scenery and totally ignoring Paul's running commentary about her driving.

Pat was an avid supporter of the arts scene and an active member of the Hills community where she was part of the Stirling Book Club, Probus and the Mt Lofty Golf Club, and she maintained a lively interest in all around her.

When she retired, she announced she intended to follow other interests such as gold-panning, walking, travelling, and spending time with the dog, her grandchildren and at the theatre. She took her grandchildren to many theatre productions and events at the Festival Theatre, fostering a love of the arts.

Pat died aged 91 and is remembered as a person of 'essential kindness', as well as a caring doctor and adventurous spirit.

Dr Richter during her last trip to Newcastle Upon Tyne in England in 2009

Elite and active

Motoring writer Dr Rob Menz has turned his attention to two Hyundai vehicles as he contemplates spring motoring.

Since its introduction to Australia in 2007, the Hyundai i30 hatch has won a slew of awards and established itself as one of the country's best-selling hatches. The i30 sedan debuted in Australia last year.

The Hyundai Elantra has been around for even longer in various forms, and since 1990 as a compact sedan. Last year the Elantra name was dropped, and the sedan renamed i30. Hyundai i30 now outsells its main rival, Toyota's venerable Corolla, which is also available in hatch and sedan form.

The test car was a mid-range, intense blue Elite model. Other available colours include black, white, grey and fiery red. The sedan range includes a basic model called Active, which is available in manual and automatic and starts at just over $28,000 driveaway. The Elite sedan is only available in automatic and sells for $34,000. These two models share a 2L naturally aspirated four-cylinder 117 kW engine. For those who want more power, there is an N-line that starts at $33,700 for manual and extends to $41,000 for the auto-only Premium. The N-line models have 1.6 turbo-charged engines producing 150 kW. For more power again you could choose the manual-only i30 fastback with its fabulous 2L 202 kW turbo- charged engine. All i30s are front wheel drive.

Hyundais come with a five-year unlimited kilometre warranty with fixed price servicing that works out at just under $300 a year and can be purchased when you collect your vehicle.

The Active model includes Hyundai's Smart Sense safety basics, which include automatic emergency braking, lane follow assist, adaptive cruise control and automatic headlights.

The Elite model adds extra safety features including blind-spot collision avoidance and rear cross traffic and rear parking vision avoidance. There's a 10-1/4 inch screen the same size as the digital dash and automatic wipers, a Bose stereo, pushbutton start and keyless entry. The N-line Premium includes creature comforts such as heated and ventilated front seats and a sunroof.

This is a very smart looking car with a modern profile, including a fabulous honeycomb front grill flanked by LED day running lights. I quite liked the small spoiler built into the boot, although the view from that angle is not to everyone's taste. The boot is a handy 474L, and the rear seats can be folded down. Likewise, the car's interior is very modern and I really like the asymmetric design with a panel running on the passenger side of the centre console. The aforementioned touch screen is subtly angled towards the driver and sits discreetly in the dash. Beneath the continuous air conditioning vents is a strip of ambient lighting. The pale grey leather seats add a feeling of luxury associated with much more expensive European brands.

'Zip' for city driving

Hyundai has done extensive road testing in Australia, and it shows in the sedan's excellent road manners. Hyundai has done an excellent job in finding the right balance between handling and comfort, with comfortable yet very surefooted ride. There are three driving modes: eco-, normal and sport and the electronic dashboard changes colour depending on the mode. There is plenty of zip for urban driving and sufficient power for safe overtaking on country roads. Hyundai has not released any acceleration figures. The suspension is well sorted and the sedan handled some of our less-than-perfect roads remarkably well. The sedan has a relatively low centre of gravity, and this made easy work out of some winding Adelaide Hills roads.

Driving included a mixture of city driving to and from work, a day trip to Clare for a family birthday and a lunch at the delightful Anderson Hill winery where we sampled an excellent pinot and a chardonnay – just the right accompaniments for the woodfired oven pizza.

… and for those seeking something a little bigger.

The second half of this Hyundai winter double is the range-topping Palisade. This large SUV was introduced to Australia recently and is the ideal machine if you're after a car of this size but don't wish to pay the premium for a full-size Toyota Land Cruiser, or Nissan Patrol.

Although similar in size and people-carrying capacity to the aforementioned 4WDs, the Palisade would not be the first choice for tackling the Simpson Desert or towing a large caravan. But if these are not your main criteria the Palisade is certainly worth a look.

To start, I have been unable to determine why Hyundai chose this name given that a Palisade is a fence of wooden or iron stakes for enclosure. Perhaps it is related to the purpose of a Palisade, which is to keep the occupants safe and secure.

With Palisade you have a choice of two models and two engines. On test was the entry-level 2.2L 147 kW 448 NM all-wheel-drive diesel. The alternative is a 217 kW 355 NM V6 with front-wheel drive. Both models use an eight-speed automatic transmission. The higher model is called Highlander, which has a number of safety and luxury features including 20- inch wheels, sunroof, electric tailgate, heated rear seats and the choice of seven or eight seats.

As with many modern cars, the Palisade is brimming with safety features. Most manufacturers seem to have their own acronyms for these. Hyundai uses 'LFA' (lane following assist), 'KLA' (keeping lane assist), 'DAW' (driver attention warning), 'RCCA' (rear cross traffic collision assist) and others. These actions are designed to ensure that the driver and the passengers are kept safe by ensuring the driver is aware of traffic around them, as well as by providing alerts if the driver is becoming inattentive.

A couple of very neat features I've not seen before include a function called 'driver talk', which includes a high-definition microphone and Palisade's audio system that allow the driver to speak to second and third-row occupants without raising their voice. The system automatically compensates for road and wind noise as the vehicle speed rises, so the driver can always be heard clearly through the C-pillar speakers. There is also a quiet mode that mutes the speakers in the rear.

The driver and front-seat passengers have heated and electrically multiple adjustable seats. The driver's position has a commanding presence on the road and excellent visibility, typical of large SUVs. There is a neat seven-inch full LCD dashboard and a 10.25-inch infotainment screen in the middle of the dash. The LCD dash has several displays, one of which shows how much power is going to each of the wheels. There is no gearstick as such – drive being selected using the SWB (shift by wire) buttons. There are also paddles mounted on the steering wheel to allow gear selection.

Comfort first

A dial in the centre console allows a choice of different driving modes, from Comfort through Eco to Sport. Although the off-road capability was not tested on this occasion, there are settings for mud and snow.

The large bulk does make manoeuvring in tight places tricky but once on the road the Palisade does feel surprisingly nippy around the city. The multi-adjustable seats allow perfect driver positioning, ensuring a driver can feel fresh even after a long drive; that warning device was not activated once.

A visit to Port Augusta with my mother to spend the day with her only great-granddaughter was a perfect excuse to test the Palisade's cruising capability.

Hyundai engineers have conducted extensive testing in Australia to check that the suspension settings are suitable for Australian roads. This work has paid off: the cabin is remarkably quiet at highway speeds and the car felt very steady. There was certainly sufficient power for safe overtaking and, with the adaptive cruise control and 'lane keeping assist', it's not too far from autonomous driving. Apple CarPlay meant we were entertained.

I was fortunate enough to have this test car for two weekends, allowing a trip for five people to the Langhorne Creek wine region. The passengers remarked on the quality of finish and drive and were impressed by their individual air-conditioning controls (including in the back seats) and USB outlets. However, between us, we were not able to find all of the promised 16 cupholders. There was plenty of room in the cabin for us all, and the capacious boot easily held more than a dozen boxes of wine for cellar restocking

In summary, the Palisade is a large, comfortable and competent SUV and well worth a look if you're in the market for such a machine.

Test cars were provided by Hyundai Australia.

Dr Robert Menz is a GP with an interest in cars. He is sadly missing his long-time driving partner Dr Phil Harding. If any member is interested in a guest editorial, please contact Rob by emailing editor@amasa.org.au.

AMA(SA) ADVOCACY SHOWCASED ON WEBSITE

AMA(SA) has advocated for doctors' and patients' interests on a wide range of issues in recent months.

Once approved by AMA(SA) Council, the submissions are available for member and public viewing on the AMA(SA) website.

Submissions that have been uploaded onto the site during 2021 relate to:

- changes to the Motor Accident Injury Accreditation Scheme rules
- proposed changes to ReturntoWorkSA fees
- the Suicide Prevention Bill 2020
- the Draft Residential Eating Disorder Treatment Program High Level Model of Care
- RTWSA revised impairment assessment guidelines
- the draft South Australian Tobacco Control Strategy 2021-2025
- insufficient negative pressure rooms in the state's public hospitals
- the COVID-19 vaccination rollout in South Australian correctional facilities
- the proposal to establish an Australian Remote Medicine Academy.

Some of these issues are discussed on other pages in this issue.

SEPTEMBER COUNCIL MEETING

The next meetings of the AMA(SA) Council will be held on the evening of Thursday, 2 September 2021. There is no meeting in October.

Members may attend Council meetings. If you are a member and wish to attend the September or November meeting, please call 8361 0100 or email admin@amasa.org.au for up-to-date information about online or face-to-face formats that may be in place.

SAVE WITH YOUR AMBASSADOR CARD

Current financial members can take advantage of Australia's premier member benefits program, The Ambassador Card, which is your key to savings with over 3,500 benefits. This is a digital program and can be accessed through the AMA(SA) website – go to the 'Benefits and Services' page from the 'Membership' tab, and login using your SA membership ID number and your email address as the password.

HAVE YOUR CIRCUMSTANCES OR CONTACT DETAILS CHANGED?

If you've recently retired or changed to part-time employment, moved to a different type or place of employment, graduated fro medical school, or otherwise changed your circumstances, please let us know.

We want to ensure our records are correct, so we can discuss the best membership category for you. Please let us know of any changes to your contact details.

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

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

HOOD SWEENEY EVENTS SUPPORT FINANCIAL PLANNING

Our financial planning and accounting services partner Hood Sweeney is staging events at their offices on South Terrace specifically targeted at our members in August and November.

On 31 August, participants can learn more about the superannuation system. Wine and cheese will be served as Hood Sweeney Health Team members discuss and answer questions about public, industry and self-managed super funds and other topics.

Doctors considering a move into investing in shares or property may wish to attend the wine and cheese event on 16 November, when the Health Team members will share their knowledge about how best to embark on investing.

For more information, please contact Emma Hart at AMA(SA) Business Support on 8361 0108 or at membership@amasa.org.au.

HAMILTON HOUSE

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

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

Richard also consults fortnightly at Morphett Vale and McLaren Vale, and monthly at Victor Harbor and Mount Gambier/Penola. He is available for telephone advice to GPs on 8272 6666 or 0408 818 222, and 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 Richard's friendly staff at Hamilton House 8272 6666. www.hamiltonhouse.com.au

ROSE STREET CLINIC

Rose Street Clinic has a wonderful opportunity available for VR General Practitioner to join our practice.

We are located in Glenelg and have an experienced and welcoming team of General Practitioners, Registered Nurses, management, and administration staff.

We are a mixed billing practice and are open five days a week with flexibility in consulting sessions.

Rose Street Clinic is a Practitioner owned practice. A steady patient base and plenty of scope for long-term progression. We offer an attractive remuneration offer of 70% of gross receipts.

Requirements:

- AHPRA registration
- Full Australian working rights
- Basic Life Support
- Covid-19 Vaccine Training

COLORECTAL SURGERY

Medical consulting suites for lease on Wednesdays and Fridays:

Colorectal Surgery, 480 Specialist Centre, 480 North East Road, Windsor Gardens.

Beautifully appointed rooms in a new medical centre. All fittings and furnishings required to start consulting today are ready and waiting. Computers, phones, internet and parking are all included. Spacious waiting area with near by café. One room @ $150+GST/half day or $300+GST/full day or rent the whole office (3 consult rooms plus a reception/waiting room & kitchen) @ $400+GST/half day or $800+GST/full day. Short or long term lease periods are available.

Membership benefits update

AMA Careers Service

Need a little career guidance? AMA(SA) members can access the AMA Careers Service for free. Services include an initial 15-minute telephone discussion with a career consultant to discuss any career-related matter and a 15-minute telephone discussion with a career consultant to review the current state of your resume. To access this service, log in to the AMA website and view 'AMA Careers Service'.

Ambassador Card

AMA(SA) offers its members a range of discounts through the Ambassador Card. Father's Day is just around the corner and Ambassador Card have some great offers to help spoil Dad this year. Choose a Dan Murphy's eGift card and save 5% when purchasing online, another great choice is the Super eGift card saving 7.5% when you purchase online at BCF, Supercheap Auto or Rebel stores and online. Is Dad more of a reader? Why not save 14% off online purchases with isubscribe. Or treat Dad to a dinner at the Indian Tandoori Palace at Evandale or Nonna & I at Kensington Park and save 25% off the total bill.

To access all these offers and more log in to the AMA(SA) website, and don't forget to enter the monthly draw.

Medical Journal of Australia [MJA]

A reminder to members that MJA will no longer be posted to member and is only available as an e-journal. The MJA e-journal has been developed to allow you to receive an entire journal issue via your email, on the day the issue is released. All the MJA issues will be securely stored on our website for you to access anytime. To continue receiving the MJA uninterruptedly please let us know your best email address at e-journal@mja.com.au.

AMA Fees List

The Fees List is available exclusively online. AMA Members will continue to have unlimited, free access to the Fees List. Non-members can purchase annual subscriptions to the Fees List, visit https://feeslist.ama.com.au/.

We want you to benefit as much as possible from your membership. If you have any questions or feedback, please contact Ms Emma Hart on 08 8361 0108 or emma@amasa.org.au.

AMA SOUTH AUSTRALIA

HOODSWEENEY

PLANNING FOR SUPER SUCCESS

31 August 2021, 6pm
Hood Sweeney, 11-16 South Terrace, Adelaide

Do you want to gain a better understanding of the superannuation system, including current rules and the many benefits of superannuation?

Join us for a presentation by Hood Sweeney Health Team Members Heang Lay, Manager Accounting & Business Advisory, and Isaac Kalleske, Representative of Hood Sweeney Securities, for an informal evening with wine and cheese as they discuss all things super. You'll be able to ask the questions you have about Public, Retail, Industry and Self-Managed Superannuation Funds.

Free event for AMA(SA) members

Register
https://www.trybooking.com/events/landing/793638

READY, SET, INVEST

16 November 2021, 6pm
Hood Sweeney, 11-16 South Terrace, Adelaide

Ready to start investing in shares or looking to purchase your first property? Want some guidance on getting started?

Join Hood Sweeney Health Team Members Heang Lay, Manager Accounting & Business Advisory, and Isaac Kalleske, Representative of Hood Sweeney Securities, for an informal evening with wine and cheese as they discuss and answer your questions on property, shares and other types of investments.

Free event for AMA(SA) members

Register
https://www.trybooking.com/events/landing?eid=793657

Contact - Emma Hart, membership@amasa.org.au or 08 8361 0108

AMA
SOUTH AUSTRALIA

Together we are **stronger**

When you take out an insurance policy or home loan from AMA Insurance Brokers or AMA Finance Brokers, all profits are returned to the medical profession, ensuring a stronger future together.

At AMA Insurance Brokers and AMA Finance Brokers, we do not have a conflict of interest. Our staff are not remunerated through commission systems. This structure ensures we only have our clients' best interests at heart, and act accordingly

Visit **amainsurance.com.au** or call **1800 262 346.**

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