medicSA
DECEMBER 2020 VOLUME 33 NUMBER 6

2020 vision

From climate to COVID, a year like no other

AMA SOUTH AUSTRALIA

PANDEMIC PERSPECTIVES • SUGAR, NOT SWEET • BUSHFIRE IMPACTS
CULTURE WARS • DECRIMINALISING ABORTION • COMMITTEE UPDATES

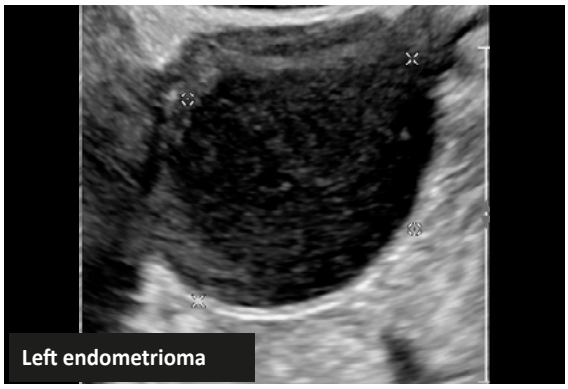
DR JONES & PARTNERS
MEDICAL IMAGING

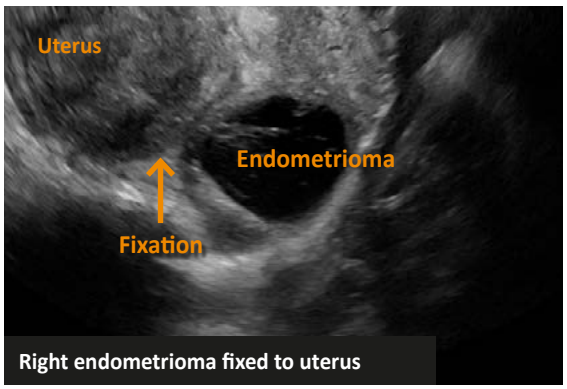
Ultrasound for Endometriosis

Taking pelvic ultrasound to the next level

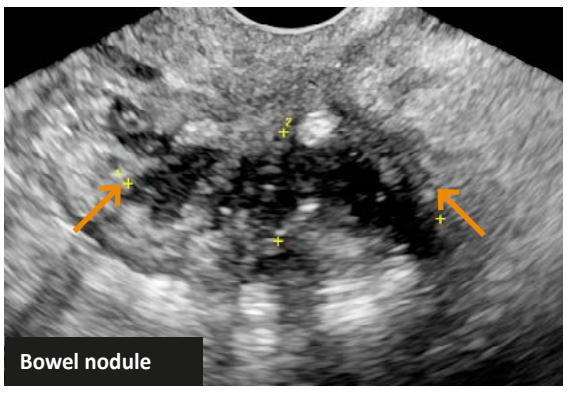
Endometriosis affects one in ten females, but the diagnosis is often delayed and a static pelvic ultrasound may be reported as normal.

> The targeted use of dynamic transvaginal pelvic ultrasound for women experiencing pelvic pain is more likely to detect endometriosis.


Left endometrioma



Right endometrioma fixed to uterus


Bowel nodule

Dynamic Pelvic Ultrasound at Dr Jones & Partners

+ Screening questionnaire to identify risk factors for endometriosis

For at risk patients:

+ Structural assessment for adenomyosis and endometriomas
+ Dynamic transvaginal pelvic ultrasound to detect fixation of the uterus or ovaries
+ Posterior fornix assessment for deep infiltrating endometriosis involving the Pouch of Douglas, recto vaginal septum and bowel

A normal ultrasound does not exclude widespread superficial endometriosis, but a dedicated dynamic pelvic ultrasound is significantly more likely to detect changes associated with endometriosis earlier.

How To Refer

A pelvic ultrasound in the diagnosis of Deep Infiltrating Endometriosis is Medicare rebated. It can be referred by both GPs and Specialists (request Pelvic Ultrasound "Query Endometriosis" or "Dynamic Pelvic Ultrasound").

For patient information about Transvaginal Pelvic Ultrasound visit:
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'Zoom' images:
Top row, from left - AMA(SA) Vice-President and Council Chair Dr Michelle Atchison during a Zoom Council meeting, bushfires on Kangaroo Island (image Blue Razoo), AMA(SA) President Dr Chris Moy.
Middle row, from left – Professor Nicola Spurrier and Health and Wellbeing Minister Stephen Wade in one of their first coronavirus media conferences, the virus (image Rost-9D, iStock), AMA House after the May fire.
Bottom row, from left – Australian of the Year Dr James Muecke, AMA(SA) Culture and Bullying Summit keynote speaker Professor Michelle Tuckey, AMA Federal President Dr Omar Khorshid.

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We've all been in it together … and we've all found ways to try and cope with the pandemic and its ramifications. One trend that has brought smiles to faces of many people, adults and children alike, in South Australia has been the placement of teddy bears and their stuffed peers in windows and gardens, to provide some sunshine in the lives of passers-by in the dreary days of lockdown. It's been a bit of fun for the doctors and staff of Chandler's Hill Surgery – but other impacts haven't been so entertaining, as Dr Kerry Hancock explains.

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Life in a year

President's report

Dr Chris Moy

Along with most people, I feel as if time in 2020 has warped and weaved – some days seem to have passed in a matter of hours, while others have felt like weeks. It is staggering that we are nearly at the end of what has been for everyone, everywhere, a most tumultuous year.

This time a year ago, AMA(SA) CEO Dr Samantha Mead and I visited doctors and hospitals on Eyre Peninsula and witnessed firsthand what we knew was the dire situation of health practitioners looking to care for patients and communities in that region. We returned filled with resolve to fight for genuine improvements after listening to the personal stories of the region's doctors and hearing of the challenges which they had to overcome to care for their communities.

Then came summer and the bushfires that raged across the country and rightly occupied the nation. The world watched and did what it could to help as South Australians, along with our neighbours in the eastern states, battled the worst fires in the nation's history. The 'Black Summer' killed 34 people and charred more than 18 million hectares of land. The ongoing health impacts are still being measured and assessed.

In late 2019, in a terrible premonition, the AMA issued a strong statement about the need to act against the 'global health emergency' that is climate change. This statement – on October 26, no less – coincided with the beginning of the summer's fires. It called on the federal government to take urgent action to reduce the risk of more climate-related disasters. As I write this, it is nearly 40 degrees Celsius, and it is still November. Action cannot come soon enough.

The immediate threat of the bushfires was still with us as a new and very different threat reached our shores. Since the term 'novel coronavirus' entered our consciousness, our lives and, for many of us, our livelihoods have been turned upside down through illness, death, and economic impacts and uncertainty. There is much said about COVID-19 and its impacts later in this issue; here, I'll just say that while it has been devastating to so many people, we must be thankful that through wise, science-based management, and a measure of luck, Australia has had fewer than 30,000 cases while, as I write this, the state of Texas, which has a population about the same as that of Australia, has had more than 1.2 million cases.

As doctors, we have been at the frontline of the pandemic. We have supported and cared for our patients through some of the most sickening and frightening days of their lives. We have advised them about what to do, sometimes amid rapidly changing and even conflicting information. Time and time again, we have donned masks and gowns and other PPE and put ourselves – and so too our families – at risk.

And this is while dealing with our own anxieties. For, despite and perhaps because of the information which I have had, I admit to experiencing genuine fear at key moments during this year like no other.

With so much evidence of the trust placed in us, perhaps it is little wonder that in mid-November the Governance Institute of Australia's Ethics Index 2020 – a survey of 1,000 Australians – found that GPs are, after fire services workers, perceived as the most ethical workers in Australia and more ethical than the same survey found a year ago. The AMA is ranked among the top five most ethical organisations in Australia, and the most ethical member organisation. We have 'done good' this year, and our patients have noticed.

In a year when the challenges have been immense, our profession has stood up and inspired. I hope that among the hardship there has been a reaffirmation in each of us about what it is that is important in being doctor. And, together as a profession, I would like to believe that we can sustain this, and for this to be reflected in our patients maintaining their deep trust in our skills and sense of ethical behaviour, and the knowledge that we will always put them first.

That is worth more than any other present under our Christmas tree.

On behalf of the AMA in South Australia, thank you all for your hard work and sacrifices this year. It has been an outstanding effort, collectively and individually, from our members and our profession. Best wishes for a healthy and safe holiday season from all of us at the AMA.

Editor's letter

Dr Philip Harding

At the present time, it is difficult to reflect on almost any issue without considering the impact of the COVID-19 pandemic. One particular matter which confronted me as I wrote this was the news that almost 200 doctors had now died of coronavirus infection in Italy, many undoubtedly in the course of their medical work. It is hard to imagine having to cope with the impact that would have on our workforce, our colleagues and our patients if it happened here in Australia. We can only hope that a vaccine will soon be available to help the efforts of health care workers here and around the world.

Mention of the word 'vaccine' leads me to draw attention to the review I have written (page 55) of the book *The doctor who fooled the world* by British journalist Brian Deer. It catalogues the somewhat fractured career of Andrew Wakefield (no relation to the Edward Gibbon Wakefield who was prominent in the colonial development South Australia), a British consultant physician and clinical researcher whose dubious practices ultimately led to his deregistration by the UK General Medical Council in 2010. Vaccines are a major theme of the book. Anyone who quickly wants to learn more about this could do no better than to do a simple Google search on the term 'Andrew Wakefield'. Otherwise, please read the review and, if sufficiently interested, the book itself.

I also draw attention to the motoring segment in this issue, a report by Robert Menz on an electrically driven Volvo; *medicSA* has in the past two years published reports on a number of electric cars as we feel them to be of particular interest to our readership in terms of their low environmental impact. As we head into another summer, the health of our environment, along with that of our friends, family members, patients, and colleagues, will be very much on our minds.

Best wishes to you all for the festive season. After the year we've had, some relaxation will be very much appreciated by everyone.

Survey to assess performance

The pandemic has brought a lot of attention to the AMA, nationally and in South Australia.

Across the country, time and again, AMA leaders including incoming Federal President Dr Omar Khorshid and new Vice President and AMA(SA) President Dr Chris Moy have been asked to explain, comment on and discuss the ramifications of the COVID-19 virus and associated policies.

Nationally and in each state, the AMA has advocated for policies, guidelines and legislation that have helped doctors and health practitioners do their jobs, and assisted individuals and communities manage physical and mental health issues directly and indirectly related to the virus and lockdowns.

Our advocacy helped accelerate the rollout of telehealth and electronic prescriptions, urged government to provide appropriate personal protective equipment, and negotiated for workable public-private arrangements in the early days of the pandemic.

Now, as 2020 comes to a close, the AMA in South Australia wants to know how the state's doctors – members and non-members – perceive it has performed during possibly the most health-focused year in memory. We're asking that you complete a brief survey to tell us what's been most important to you, and how the AMA could support you in 2021 and beyond.

If you're a doctor who is an AMA member, please complete the survey here. If you're a non-member doctor, a slightly different survey is available here.

The survey is open until 15 January 2021. The results will help guide our advocacy and improve our communication with you. We hope you'll participate – to help us help you.

SAVE THE DATE!

THE AMA(SA) GALA DINNER WILL BE BACK NEXT YEAR, ON 22 MAY 2021.

Please watch out for details in The Voice in the new year, and the February issue of *medicSA*.

Swings and roundabouts

It's been a year like no other for doctors, patients and AMA(SA). CEO Dr Samantha Mead dons not-so-rosy glasses to look back on 2020.

The Queen in her Christmas message in 1992 described that year as an annus horribilis. One can only imagine the phrase she will use to sum up 2020. 'Unprecedented' seems to be the word of the year so perhaps she'll stick with that.

There is no question that 2020 has been heart-breaking and challenging for so many. If there is an upside, it is that 2020 has taught us how quickly we can adapt to change.

If I think back to the beginning of the year, I remember most the devastating fires. I felt for those who had endured loss and fear: experiences I understood having lost members of my community and my own home in the Ash Wednesday fires.

As a membership organisation and advocate for public health, AMA(SA) mobilised to help those supporting their communities ravaged by the bushfires. We noted that many doctors involved as first responders were likely to be traumatised by the experience. As a profession, doctors needed to be on the look-out for signs of mental-health impacts of the bushfires.

The AMA campaigned for resources to help with the ongoing mental and physical impacts of emergencies and through organisations such as DRS4DRS. At the same time, we advocated for better protocols to enable doctors to work effectively with emergency services and to recognise the important role GPs play in supporting fire-ravaged communities.

The beginning of the year was also when we started to hear more about the spread of a novel coronavirus: the dreaded COVID-19. Immediately, the AMA(SA) had to jump into action – like all businesses around the country, evaluating and mitigating risks and adapting to new work practices.

We had perhaps never been busier, helping inform the community about the public health response and supporting our members as they tackled challenges on almost every front – personal, professional, social and economic.

Our organisation faced its own challenges with a random arson attack badly damaging AMA House. By then, staff were working from home and 'meeting' via ZOOM; later, as restrictions eased, we moved into temporary accommodation in Dulwich.

Despite these challenges, we were reminded of how much we can achieve when we pull together – as our fearless leader, Dr Chris Moy, would say. AMA(SA) swung its support behind the campaign to elect Dr Omar Khorshid as Federal AMA President and Dr Moy as Vice President. While this has led to a crazy amount of work for the latter in his dual state and federal roles, it has become very clear how valuable it is to have Dr Moy in a national leadership role. His passionate advocacy and voice of reason throughout the pandemic have been a source of assurance to colleagues and the community around the country.

And, of course, despite the various crises we have managed throughout 2020, we have also stayed the course with our agenda to push for culture change in the public health system and to support doctors' wellbeing.

Other important work has also continued, including advocating for resources to improve conditions for rural doctors, to decriminalise abortion, and to support clinicians at the Women's and Children's hospital in a time of flux.

This year has allowed us to 'bring our whole selves to work' and we became aware that you never know what people are going through beyond collective challenges such as COVID and bushfires. We also could not fail to recognise the value of the AMA in speaking for doctors, colleagues and patients in the face of unexpected and unceasing threats. But as we approach 2021, we in AMA(SA) can only hope that – perhaps with the aid of tried and tested vaccines – the next few months are healthier, happier and slightly less challenging for us all.

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Open 24/7 **Emergency Department Open 8am–10pm**	**Open 24/7**	**Open 24/7**	**Closes 18 Dec 2020** **Reopens 6 Jan 2021**	**Open 24/7**

In the thick of it

Climate change, bushfire prevention and vaping joined aged care as key advocacy issues for the AMA in 2020.

AMA President Dr Omar Khorshid

The AMA has joined the Business Council of Australia in backing the Climate Change Private Member's Bill introduced by Independent MP Zali Steggall.

The aim, says Ms Steggall, is to use framework legislation as has been done in the UK, France and Ireland to introduce mandated targets and remove the politics from Climate Change policy.

Ms Steggall said the legislation was needed following recent bushfires and the drought which showed climate change to be an immediate challenge.

'The provisions within the Climate Change Act ensure there are equitable, transparent and science-based plans to address the impacts of climate change, prevent worsening consequences and take advantage of economic opportunities,' she said.

The proposed Climate Act will mandate:

- a National Climate Risk Assessment
- a National Adaptation Program
- a Net-zero target by 2050
- establishment of an independent Climate Change Commission.

AMA Vice President Dr Chris Moy said sensible, non-political legislation is needed to embed Australia's obligations to reach Paris Agreement targets.

'Just as the government has responded so well to the COVID health emergency by listening to the science and evidence, we ask that they do the same for the health impacts of climate change,' Dr Moy said.

The AMA has also urged the government to implement the recommendations of the Royal Commission into National Natural Disaster Arrangements to reduce the health and human cost of future bushfire seasons, and other natural disasters.

Its recommendations echo the AMA's long-standing call for GPs to be more involved in disaster planning, and to prioritise mental health services during and after natural disasters.

'The Royal Commission also acknowledges that further global warming is inevitable and will contribute to more frequent and intense natural disasters,' AMA President Dr Omar Khorshid said.

'The AMA recognises that climate change is a health emergency, with clear scientific evidence indicating severe impacts for Australians now and in the future. Last summer's unprecedented bushfires were a devastating demonstration of this.'

The AMA and Doctors for the Environment Australia (DEA) have called on the federal government to adopt a suite of key measures to help reduce the risk of further climate-related disasters.

This includes:

- a national climate change and health strategy to facilitate planning for future climate health impacts
- an ambitious reduction in Australia's greenhouse gas emissions aligned to science-based targets
- an Australian Sustainable Development Unit to support environmentally sustainable practice in healthcare and reduce the sector's own significant emissions
- policies that acknowledge the health benefits of a transition to renewable energy.

The AMA has also called for a national Centre for Disease Control to educate the public about large scale-disease threats, including air and water quality.

'As Australia recovers from the acute phase of the COVID-19 pandemic and adjusts to ongoing restrictions and economic changes, it's important that we also prioritise the health impacts of climate change,' Dr Khorshid said.

'The 2019-20 bushfire season in Australia had severe health consequences. Along with more than 30 tragic deaths directly attributable to the fires, exposure to bushfire smoke caused an estimated 417 excess deaths, 1,124 hospitalisations for cardiovascular problems, and 2,027 hospitalisations for respiratory problems.'

AGED CARE MODEL FALLS SHORT

The AMA has criticised a proposal for a new primary care model for nursing home residents, arguing this will cut out the person's regular GP and further fragment care.

The key feature of the proposed model is that a GP practice would have to be accredited to work in aged care. An older person entering a nursing home might have to abandon a trusted GP and find a GP who has aged-care accreditation.

Dr Khorshid said the proposal to allow aged care residents to enrol with niche, accredited general practices may discourage many GPs from providing care to aged care residents.

'With our population living longer and entering residential aged care at older ages and in more frail states of health, we should be aiming to bring aged care and health care closer together, not further fragment them,' he said.

'Although the AMA is pleased with many of the Aged Care Royal Commission recommendations, they've missed the mark when it comes to better access to health care and improving the model of GP care.

'The AMA is very concerned that the proposed new model will be a two-tiered system where continuity of care would be discarded to the detriment of our elderly for the convenience of aged care providers.

'Devising new models of care should not be a substitute for improving inadequate MBS rebates that do not recognise the complexity of care being provided to aged care residents.'

The AMA supports mandating minimum staffing ratios in aged care and has called for registered nurse availability in aged care 24/7, with the aim of bringing staffing ratios closer to a five-star model.

Recommendations include a new Aged Care Act based on human rights principles for older people, mandated staffing ratios in nursing homes, demand driven access to aged care, and a new and independent process for setting aged care quality standards.

VAPING DECISION CLOSES LOOPHOLE

A proposal to prevent people from accessing nicotine without a prescription is an important step in the process of preventing smoking and vaping although it may initially spike demand, says Dr Khorshid.

The Therapeutic Goods Administration (TGA) has proposed to stop people accessing nicotine for any use without a prescription and will ensure patients see their doctor for advice on the most reliable and safe methods to stop smoking.

... the evidence that vaping is effective as a quit smoking aid is inconclusive, but there is plenty of evidence that it causes harm ...

The AMA is keen to ensure that nicotine use – both in smoking and vaping – is increasingly limited given the overwhelming evidence that it is universally harmful. It is also wary of claims that vaping is a useful quit-smoking aid.

'Nicotine is a poison, and the AMA opposes all use of nicotine-containing vaping products,' Dr Khorshid said. 'Exposure to nicotine can harm adolescent brain development, and nicotine vaping products contain carcinogens including formaldehyde and solvents.

'The evidence that vaping is effective as a quit smoking aid is inconclusive, but there is plenty of evidence that it causes harm. Multiple studies show that vaping can lead to previous non-smokers taking up tobacco smoking, and that people using vaping as a quit aid are significantly more likely to still be vaping after a year than people using nicotine patches or other therapies.

'While doctors can already prescribe nicotine for vaping, it is very rare – the TGA estimates that only about 10 doctors in Australia currently do so.'

Dr Khorshid said there is no TGA-approved nicotine vaping product, due to a lack of evidence of their efficacy or safety.

'Their use should be only as a method of last resort,' Dr Khorshid said.

'Doctors will need clear and well-communicated guidance on appropriate dosages and recommended timeframes for use. The AMA recommends including a time limit for prescribing these products to ensure that patients who do not intend quitting cannot have access to an ongoing supply.

'The prescribing criteria must also specify that nicotine-containing products may only be prescribed to current smokers, and we strongly recommend that the changes should be evaluated after 12 months to assess the impact on smoking rates.'

Patients adopting digital health services

The pandemic demonstrated the vital need for widespread digital health services in Australia – and now they're here to stay.

Since Medicare Benefits Schedule (MBS) item numbers were created to enable safe access to medical services including GP and specialist services during the COVID restrictions, patients and doctors have embraced telephone and video consults – but only when supported by face-to-face treatment.

The AMA is now working with the Australian Government to embed telehealth into the Australian healthcare system and permanently enable telehealth consultations to be subsidised under the MBS.

'The temporary COVID-19 arrangements have allowed us to test the model, and have shown where refinements can be made,' AMA President Dr Khorshid said.

Announcements in November indicated MBS-funded telehealth arrangements will be finalised by the next federal budget.

'This will represent the biggest reform to Medicare since its introduction,' Dr Khorshid said.

'Telehealth will not replace face-to-face care, but it does support better access to care for patients, including by supplementing face-to-face care or by supporting patients with barriers to care, such as those in rural areas.'

The AMA expects its proposal that patients enrol with a general practice to build a relationship with their usual GP will be part of the permanent model of MBS-funded telehealth.

'It gives patients much more flexibility in how they can access care from their usual GP or treating specialist, particularly when they do not require a physical examination,' Dr Khorshid said. 'This saves a patient's time and money and often means they do not need to take time away from work.

'Telehealth enables doctors to better support their patients to access care when they need it.'

Meanwhile, the federal government has committed $2.4 billion to provide all Australians with access to telehealth, with more than 30 million Medicare-eligible telehealth services delivered since March.

A $5 million investment has been made to fast track electronic prescribing, and $25 million has been provided to support home delivery of medicines.

From May to late November, more than 1 million electronic prescriptions were issued, including over 800,000 original electronic prescriptions and over 400,000 repeat tokens to patients.

The use of My Health Record by healthcare providers has also grown significantly, providing Australians with secure access to their health information.

Since March, the volume of documents uploaded by healthcare providers such as hospitals, pathologists and radiologists increased by 40 per cent. There are now more than 275 million clinical and medicines documents in the system that were uploaded by healthcare providers.

GPs front and centre in mental health treatment

The AMA has highlighted the central place of GPs in access to mental health services.

A proposal to scrap GP mental health treatment plans and replace them with an online assessment tool would be counterproductive in the quest for person-centred care, says the AMA.

While the Productivity Commission's Mental Health Inquiry Report aims to establish a person-centred mental health system, undermining the role of GPs would result in less support and more fragmented care, AMA President Dr Omar Khorshid said.

The Mental Health Inquiry Report calls for a $2.6 billion overhaul of the mental health system, estimating the total cost of poor mental health and suicide to be as much as $70 billion per year.

Speaking after the release of the report on 16 November, Dr Khorshid said the AMA 'welcomed the report's aspirations for a person-centred mental health care system, focusing on prevention and early help – both early in life and early in illness'.

'But we cannot accept recommendations that take away support for GPs at a time when the burden of mental illness is growing,' he said.

One in five Australians have a mental health consultation with their GP every year, with a satisfaction rate of more than 80 per cent.

Yet the report offers little in the way of extra support for GP care in mental health, other than the introduction of a Medicare item for GPs to seek advice from a psychiatrist about a patient in their care.

The report proposes abolishing Medicare-funded GP mental health treatment plans, which the AMA says are fundamental to engaging with a patient about their care needs. Instead, patients would be assessed using an online tool which would enable patients to bypass their GP altogether rather than having the GP coordinate a multidisciplinary team to support the patient.

'The report should have placed much more emphasis on the patient-centred medical home as the ideal model for people seeking care for their mental health,' Dr Khorshid said. 'GPs form life-long relationships with their patients, and building mental health into general practice will further enhance the role of GPs in early intervention.'

The AMA supports recommendations to address workforce shortages that make it difficult for patients to access specialist psychiatric care – particularly in rural areas.

'With the mental health sector receiving less than half the funding of the comparable burden of disease funding, one thing is clear – any government response to this report will need to be backed by much greater funding, otherwise patients will continue to struggle to access the vital care that they need,' Dr Khorshid said.

The AMA is reviewing the report's extensive recommendations.

AMA: industry attacks put profit before health

New Australian guidelines for alcohol consumption will help Australians understand the serious health effects of drinking alcohol, AMA President Dr Omar Khorshid says.

While industry groups have described the new guidelines as being overly cautious, Dr Khorshid says such criticisms are not based on evidence.

The updated *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*, released by the National Health and Medical Research Council (NHMRC), recommend that healthy people drink no more than 10 standard drinks per week. The previous guidelines allowed for 14 standard drinks per week.

The Guidelines also recommend a limit of no more than four standard drinks on any one day, and that children younger than 18 years, pregnant women, and women who are planning to become pregnant should not drink alcohol at all. Breastfeeding parents are advised that not drinking alcohol is safest for their baby.

'Drinking alcohol has a range of health effects, both in the short and long term,' Dr Khorshid says.

'Many Australians are unaware that alcohol consumption can contribute to cancer and cerebrovascular, cardiovascular, liver and digestive disease. It's important that these guidelines are not interpreted as "safe" or "allowable" levels of alcohol consumption, but as a way to reduce your level of risk.

'As the NHMRC says, people drinking alcohol within the guidelines lower their risk of dying from an alcohol-related disease or injury to one in 100. Not drinking alcohol at all is the best way to reduce your risk of alcohol-related harm.'

Dr Khorshid says the response from alcohol industry groups has been to attack the NHMRC's credibility.

'The AMA respects the NHMRC's systematic and rigorous approach to the evidence review and believes that this approach has clearly held the health of Australians as its highest priority,' he says.

In its Position Statement, *Alcohol Consumption and Alcohol-related Harms*, the AMA says:

'Australians drink a large volume of alcohol overall, and many drink at harmful levels, including teenagers and young adults. Young Australians are starting to drink at an earlier age, and most drink in a way that puts their own and others' health at risk.

'The harms of excess alcohol use are significant and warrant serious measures, especially regarding adolescents and youth. The AMA is committed to Australia achieving the greatest possible reduction in the harmful effects of excess alcohol consumption.'

Don't sugar-coat it

AMA(SA) member Dr James Muecke has spent much of his year as Australian of the Year to educate his country about the devastating health impacts of excessive sugar consumption.

Dr James Muecke, 2020 Australian of the Year

It's a cliché to say 2020 has been a year like no other. But for Adelaide ophthalmologist Dr James Muecke, 2020 has brought even more changes than for most of us: named Australian of the Year in January, he looked forward to countless speaking engagements in which he could educate and influence Australians about the dangers of sugar.

It wasn't long before COVID-19 restrictions meant that his diary switched from being filled with in-person presentations to one dominated by on-line conferences and webinars. Fortunately, Australians became familiar with the format; his message could still be delivered.

Then, in March, Dr Muecke was himself diagnosed with a disease directly related to his own excessive sugar consumption: fatty liver. As a tall, fit and apparently healthy man with no symptoms, the diagnosis came as a shock; he was, he learned, one of the increasingly common 'TOFI' – thin on the outside, fat on the inside – people who develop diet-related fatty livers.

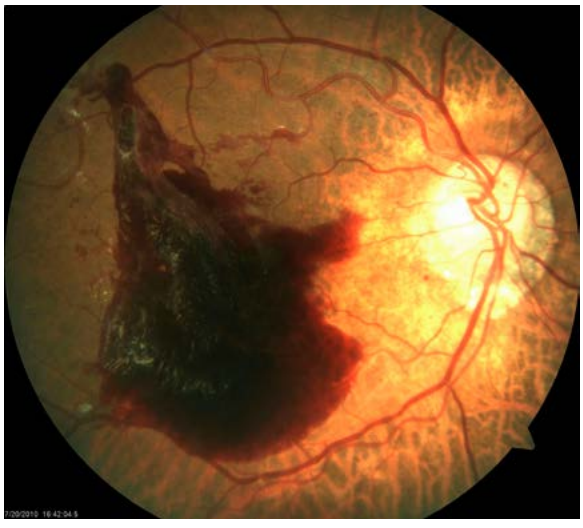
The doctor was forced to practise even more strictly what he was preaching – consume minimal amounts of the sugary products, refined carbohydrates and ultra-processed foods that cause type 2 diabetes and its associated vision loss and other major health problems, including liver disease. In his case, it meant much less ice cream and chocolate. And the lockdown stopped the temptations that come with 'on the road' dinners and late-night hotel snacks.

The diagnosis certainly gave a personal touch to his speeches. In the many presentations he's delivered, Dr Muecke explains that every year he sees increasing numbers of people losing vision and even going blind due to diabetes, especially type 2 diabetes.

'More than 150,000 Australians now have sight-threatening eye disease due to diabetes. Type 2 diabetes makes up close to 90 per cent of all cases – yet is a largely preventable dietary disease due to the consumption of too much sugar in our modern diet,' Dr Muecke says.

'Diabetes causes damage to the blood vessels throughout the body, including the retina. Diabetes can cause bleeding inside the eyes that can take away the eyesight in an instant, and sometimes permanently.

'But 98 per cent of the loss of vision due to diabetes is preventable or treatable. However, to avoid the blinding consequences of this disease, patients with diabetes need to have their eyes checked regularly. In Australia, of the 1.7 million Australians with this disease, well over half are not having their regular, all-important, sight-saving eye checks.'



Retinal haemorrhage due to diabetes

That's why, he says, diabetes is now the leading cause of blindness among working age adults in Australia, and the fastest-growing cause of vision loss among Aboriginal people.

'This is a disease that was virtually non-existent in the 1960s,' Dr Muecke says. 'Now, we see roughly 250 new cases in Australia each day.'

And, he says, the sugar and refined carbohydrates – white flour, white rice, white potatoes and the foods made from these – that comprise so much of what we eat and drink are largely to blame.

'Refined carbohydrates are pretty much pure starch and starch is simply long chains of glucose which are broken down into single molecules of glucose when they reach the gut,' he points out. 'When we ingest refined carbohydrates, we are giving ourselves a big sugar hit. And there's no biochemical process in our bodies that demands it.

'This is a phenomenally expensive disease, costing our health system close to $20 billion every single year for treatment and lost productivity. And we are now seeing type 2 in our kids. This is a disease that used to be called "maturity onset diabetes"; there are now over 1,100 Aussie kids and teens with type 2 diabetes.

'Globally, in 2001, less than 3 per cent of diabetes in children was due to type 2; by 2011, it had risen to 45 per cent. And what's really concerning is that we are now seeing type 2 diabetes in Aussie kids as young as seven.'

SO WHAT IS TO BE DONE?

'Being a dietary disease, it should be as simple as reducing our sugar intake,' he says. 'But there are a number of factors that make this difficult for us to achieve.'

With a national platform amplifying his voice and enabling him to reach more politicians, doctors and parents, Dr Muecke has urged governments and industry to enact strategies to counter what he has termed 'the 5As of sugar toxicity':

- Addiction – sugar is as addictive as nicotine
- Alleviation – we often consume sugar to make us feel better when we're down
- Accessibility – sugar is everywhere, including at supermarket checkouts and in vending machines
- Addition – about 75 per cent of our foods and drinks have added sugar
- Advertising – we are inundated with ads and commercials for sugary products.

Dr Muecke says action to counter the first two requires making people aware that sugar is addictive, and that we do consume sugary products to alleviate stress.

'For most, it will be a physical dependency,' he says. 'I went through a sugar detox after my fatty liver diagnosis and it's very unpleasant – far worse than caffeine withdrawal. For some people however, there may be a deeper, psychological addiction, and we may need to introduce help lines, self-help groups and counselling, as we've done for alcohol and nicotine addiction.

'For alleviation, people need to look to alternatives to sugary products when they're stressed. A walk in nature, music, doing a good deed have all been shown to be as effective as sugar in countering the cortisol reaction that's flooding our body during anxious times.'

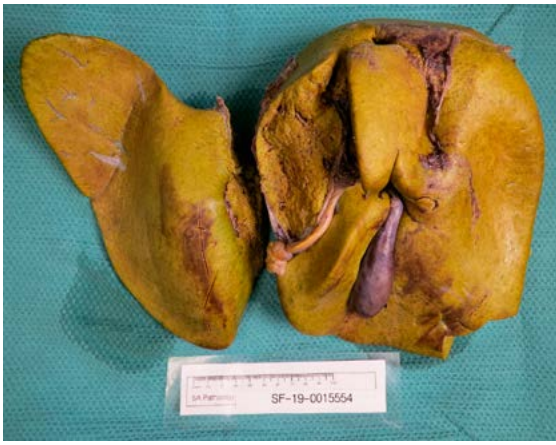
Action in the other three As demands accountability.

'We need business, industry and government to do the right thing by the people of Australia – remove sugary products from vending machines in schools, hospitals and universities, and from checkouts; agree to graphic labels that indicate the added sugar content of beverages and other products; and ban ads for sugary products in television, social media, and on government buildings and services.'

He has pleaded with the Australian Government to change the Australian Dietary Guidelines, which he says are 'packed' with products made from refined carbohydrates as well as other foods that can have relatively high amounts of sugar in them, including tropical fruits, low-fat dairy, baked beans and ultra-processed foods.

Then there is the much-discussed sugar tax. Dr Muecke says a levy on sugary drinks has already been shown to reduce purchase and consumption in 17 countries. In the 10 years to 2017, the consumption of sugary drinks in Australia increased by 30 per cent and it's been modelled that a 20 per cent levy just on sugary drinks would raise $600 million, which could then be used to fund health initiatives and combat health inequalities.

'We also need hard-hitting strategies – ads and awareness campaigns – as we did with cigarette smoking,' Dr Muecke says. 'Doctors shouldn't have to keep treating and Australians keep paying for the life-changing and life-threatening complications of a preventable and reversible dietary disease.'



A human fatty liver

Dr James Muecke explains how the excessive consumption of sugar is the leading cause of death in Australia including type 2 diabetes, heart attack, dementia and stroke.

Sucrose, or table sugar, which is the most common additive, comprises 50 per cent glucose and 50 per cent fructose. The body handles these two substances in completely different ways.

Firstly, **glucose**. When glucose is absorbed into the bloodstream from the gut it triggers the release of the hormone insulin from the pancreas. The insulin helps move the glucose into every cell of our bodies, where it's then stored or used as an energy source.

With excessive and prolonged sugar intake, the cell becomes full of glucose. The insulin level rises to push more glucose into the cell, but it reaches a stage where the cell can take no more in – which is when we become 'insulin resistant'. This leads to an overflow of glucose back into the bloodstream, which is then taken up by the liver and converted initially into glycogen.

The body has limited glycogen stores. Once these are full, the liver starts turning the glucose into fat, which is then exported away from the liver and stored in healthy fat cells around the body. But when the production of fat by the liver outstrips its ability to be exported, the liver then starts taking on that fat, and we develop a 'fatty liver'.

Fructose is the 50 per cent of sugar that gives sugary products their sweet flavour. Fructose suppresses our appetite control system. When fructose is absorbed into the bloodstream, 100 per cent of it is taken up by the liver and about one-third is converted immediately into fat. It's actually much more dangerous than glucose in leading to a fatty liver.

It takes on average about 13 years for someone to develop type 2 diabetes after they become insulin resistant. It's a complex metabolic process, but ultimately the liver can take in no more fat and the excess fat is exported away from the liver as triglyceride, which is harmful to our health. It's the high level of triglyceride in the blood, combined with the high insulin level, which leads to the formation of fatty plaques, which block the blood vessels and in turn produce the many devastating consequences of type 2 diabetes.

Blockage of the fine blood vessels can lead to impotence, numbness and pain in the extremities. It can also cause damage to the retinal tissue with bleeding inside the eye and macular oedema – damage to the fine blood vessels in the central vision area causing fluid leakage and then distortion and reduced vision.

Diabetes can also cause dementia – about 70 per cent of patients with type 2 diabetes will ultimately succumb to dementia – and kidney failure. Every year in Australia, an estimated 4.5 million hours are spent by patients with type 2 diabetes hooked up to dialysis machines.

Type 2 diabetes is now the sixth-biggest killer in our society. But if you consider it also plays a critical role in stroke, dementia and heart attack, as well as hypertension and cancer, it may well be the biggest killer in our midst.

AMA(SA) has provided public support for the decriminalisation of abortion as proposed in a Bill now before parliament, writes AMA(SA) President Dr Chris Moy.

The Termination of Pregnancy Bill presented to the South Australian Parliament in November aims to change the law so that in this state, as elsewhere in Australia, abortion is regarded by the law as a women's health issue. If passed in its current form, women seeking abortion will no longer have the threat of criminal action adding to the already complex issues they contemplate when considering whether they should or must terminate their pregnancy. Nor will suitably trained doctors and other health practitioners face such a threat.

The decriminalisation of abortion is long overdue. Women who seek abortions should not have the threat of criminal prosecution adding to the other complex and distressing factors that they face when contemplating this health procedure. Fortunately, it seems many of the politicians who must vote on this Bill agree with this major change to the legislation.

It seems that in supporting decriminalisation, the parliament is aligned with community sentiment. While some South Australians have religious or other objections to terminations that are genuine and must be respected, a survey[1] of South Australians conducted in May 2019 – results of which were released in June 2020 – found:

- two-thirds of the 1,012 adult respondents support the availability of abortion care
- 80 per cent support decriminalisation.

This Bill comes at a time when as a society and as individuals, we recognise that women should have control over their bodies and be at the centre of their health decisions.

The law as it stands prevents many women from exercising that control, especially if they live in rural or remote areas or are new to this state.

WHAT WILL CHANGE?

The Bill places control with the woman, rather than with the medical practitioner as is the case with the current legislation drafted in the 1960s.

However, it does not change anything in terms of the medical and health processes. But it does recognise that technology and health services have changed and improved, with knowledge and technology now enabling doctors to identify foetal health issues such as spina bifida, major cardiac or neurological malformations, at the 20-week scan.

This proposed legislation supports a timeline where a woman and others who may be involved to undergo scans and other tests that are now available, and have some time to consider what this information means before making what is a devastating decision. Health services provide counselling and support during this decision-making time.

Besides terminations performed by medication, a medical practitioner is required to approve and perform the procedure in the period up to 22 weeks and 6 days.

After 22 weeks and 6 days, there must be two medical practitioners involved, to ensure the procedure is medically appropriate.

There is no evidence here or elsewhere that this Bill will increase the number of late-term abortions. It didn't happen in Victoria or Queensland when the legislation was changed; in those states, approximately 99 per cent of terminations continue to be performed before 20 weeks.

The small percentage of women who seek abortions after 20 weeks, and the even smaller that do so after 22 weeks, do so almost invariably because a woman or couple who very much want the pregnancy discover through a scan at 19 or 20 weeks that the foetus has a serious health condition, or because of a risk to the woman herself.
Examples of this include:

- A minor with an intellectual disability became pregnant as a result of sexual abuse by a family member. Given her intellectual disability, she was unable to appreciate or understand

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AMA positions on abortion

The AMA Position Statement on Conscientious Objection 2019 states:

1.2 A conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards.

1.3 A conscientious objection is based on sincerely held beliefs and moral concerns, not self-interest or discrimination.

1.4 It is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection.

1.5 A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care.

The AMA Position Statement on Ethical Issues in Reproductive Medicine 2019 states:

2.4.1 Doctors hold differing views regarding abortion. Where a doctor has a conscientious objection to abortion, they must inform the patient of their objection and ensure the impact of a delay in treatment does not constitute a significant impediment to the patient accessing services. The doctor must take whatever steps are appropriate to ensure the patient's access to care is not impeded. Due to the time critical nature of abortion services, in some circumstances providing the patient with sufficient information on accessing such services may be sufficient while other situations may require an effective referral to another practitioner.

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her pregnancy until she was at a late gestational stage. When her situation became known, the girl was clear that she did not wish to proceed with her pregnancy and a late-term abortion was carried out.

- In NSW, the Health Minister noted that she sat for two hours with one young woman who very much wanted a baby but at 20 weeks a scan showed that the baby's organs were growing outside its body. It was first diagnosed at 12 weeks, but she hoped for a miracle. When she was checked at just over 20 weeks it became obvious that she had to have a termination.

THE RIGHT TO OBJECT

At the AMA's insistence – even to the point of specifying wording – this Bill recognises that some doctors and other health practitioners, as with other members of the community, do not wish to perform terminations because of genuine and long-held beliefs.

The clauses about conscientious objection reflect the submission from the AMA(SA) to the South Australian Law Reform Institute – which investigated the existing legislation, invited submissions from interested parties, and drafted a Bill for Attorney-General Vickie Chapman – and Federal AMA Positions.

I am aware that views regarding abortion are varied and deeply held among our members, members of the health profession and individuals in the community. I have and will continue to show the highest respect for these views. However, I have also chosen to be clear in supporting the Bill from the onset as it aligns with both the Federal AMA positions and the view of AMA(SA) Council as set out in its submission to SALRI, and subsequent to a request for the input of all members.

Most importantly, however, AMA(SA)'s support of the Bill is founded on the view that in 2020 it is totally inappropriate and anachronistic for the burden of criminality to be placed on a woman who is already facing a difficult decision about a matter related to her health.

[1]*Cations, M., Ripper, M., & Dwyer, J. (2020). Majority support for access to abortion care including later abortion in South Australia. Australian and New Zealand Journal of Public Health, 44(5), 349-352.* https://doi.org/10.1111/1753-6405.12997

Campaigning for care

AMA(SA) representatives have been vocal in campaigning for world-class care at the Women's and Children's Hospital (WCH) in North Adelaide throughout 2020.

From the State Budget submission forwarded to Health and Wellbeing Minister Stephen Wade in December 2019 to high-profile advocacy in the media in recent months, AMA(SA) members and Councillors have urged that plans for the new WCH ensure patients, families and carers have access to the best care.

In addition, doctors have demanded that services at the existing WCH must not diminish in quality or capacity while South Australians wait for the new hospital to be built. Long-time AMA member Dr Michael Rice – for whom the paediatric cancer ward at the WCH is named – has been particularly vocal in demanding that children continue to receive the care they need.

In December 2019, AMA(SA) President Dr Chris Moy submitted the AMA(SA) Council's list of priorities for the 2020-21 State Budget. While COVID-19 has had a dramatic effect on priorities, budgets and other resource issues since that submission, Dr Moy says planning for the WCH continues to proceed – and progress must incorporate the knowledge and expertise of doctors and other health practitioners.

In a letter to Minister Wade in October 2020, Dr Moy emphasised the importance of clinical input. 'The knowledge and expertise of our members and colleagues in the medical profession is fundamental to consideration of how the new Women's and Children's Hospital (nWCH) is designed and built to best cater for the needs of women, babies and children in the years ahead,' Dr Moy wrote.

Dr Moy says the AMA consistently argues for health services and infrastructure to be planned for, designed and used to maximise the benefits for people.

'For a new Women's and Children's Hospital, that means the planning and design stages of the physical infrastructure must address the needs of patients, carers and visitors, doctors and other healthcare professionals, and other people who must use it,' he says.

'Clinicians must also be involved in planning how the hospital will operate and be managed. This will require a clinician-led governance structure that includes innovative, talented and medically qualified administrators who are enthusiastic about healthcare and are remunerated appropriately.

'Minister Wade understands that we want clinicians to be involved in discussions about planning the hospital from day one. That didn't happen with the new Royal Adelaide Hospital, and we've seen the result: a hospital that has problems that patients and staff are forced to tolerate and find work-arounds for.'

Dr Moy says the new WCH must be ready and able to address the needs of and opportunities provided by changing demographics, social expectations and technological innovations over the 20 years or more after it opens.

'This type of planning requires input from the people who will work in and use the hospital, and so clinicians and other practitioners must be included in these discussions from day one,' Dr Moy says. 'There must be no loss of services, no loss of beds.'

For example, Dr Moy says, basing bed numbers on predicted averages is a mistake. 'Hospital bed numbers should have built-in redundancy and capacity to cater for peak periods – a clear and horrendous failure in the build of the current RAH,' he says.

'Where the views of consultancy firms and finance override those of coal-face clinicians in decision-making, you end up with fixed problems that create ongoing costs for the care of the community and Treasury – the RAH again being the prime example.'

Dr Moy says it will be several years before the new WCH is built and ready to support patient care. 'The AMA is monitoring the provision of quality care in the existing hospital and other services.'

Towards zero tolerance

The AMA(SA) Culture and Bullying Summit in February has inspired nation-leading legislation to provide safe workplaces for South Australia's health care workers.

The Summit staged by AMA(SA) at the University of Adelaide heralded a year in which working conditions for doctors – and particularly junior doctors – were the subject of discussion around Australia. The concerns regarding poor culture and bullying highlighted by state-based Hospital Health Checks (HHC) in recent years had reached a point that no one could ignore them.

In South Australia, the issue had generated front-page headlines in September 2019, after AMA(SA) President Dr Chris Moy told the Parliamentary Inquiry into Workplace Fatigue and Bullying in South Australian Hospitals and Health Services of the 'toxic' culture in the state's hospitals. Dr Moy's statement described work environments in which doctors and other health practitioners were subjected to bullying and harassment that led to stress, anxiety and fatigue.

It was not only doctors and other health care workers who suffered through such treatment, Dr Moy said: tired, stressed doctors make mistakes that have serious effects on their patients.

Dr Moy announced that in early 2020, the AMA in South Australia would bring together doctors, academics, administrators and politicians at a 'Culture and Bullying Summit', to identify bullying issues and causes and demand that 'bullying must stop'.

On 29 February, more than 100 of the state's leading health and medical minds and leaders in South Australia attended the Summit. They heard Dr Hannah Szewczyk, chair of the AMA(SA) Doctors in Training Committee, report that South Australia's HHC results mirrored those of other states in relation to workforce factors such as access to leave and professional development opportunities, rostering and overtime, and bullying and harassment.

Dr Szewczyk said most junior doctors reported concerns about making a clinical error due to fatigue, and fatigue had caused some to crash their cars. However, she said, the issue that concerned most junior doctors was their ability to claim unrostered overtime, with as many as 39 per cent reporting they had been told not to claim it.

Other speakers – MIGA senior solicitor Tim Bowen, A/Prof Christine Lai of the Royal Australasian College of Surgeons (RACS), and A/Prof Jill Benson, Clinic Doctor at Doctors' Health SA – supported her evidence.

Keynote speaker Professor Michelle Tuckey of the University of South Australia's Centre for Workplace Excellence explained that while every workplace has factors that can lead to stress and other issues that may cause bullying, those factors and the bullying itself are usually symptoms of bigger problems: the workplace systems, structure and processes.

BOARD RESPONSIBILITIES

It was a comment from Women's and Children's Hospital LHN Chair and former SA Health Chief Executive Jim Birch that led discussion at the summit back to the key question of where responsibility lies for the matter of culture within the SA Health system.

Dr Moy says this 'aha moment' has led to a ground-breaking recognition of the role of Local Health Network boards in demanding staff wellbeing as a non-negotiable 'performance indicator' in the South Australian health system.

An unequivocal statement that LHN Boards are ultimately responsible for the welfare for their staff is included in an amendment (that has now been passed) for the Health Care Governance Amendment Bill 2020 that Dr Moy and AMA(SA) Council drafted and strongly advocated for. In a letter to Health and Wellbeing Minister Stephen Wade, Dr Moy said it was important to 'be explicit in setting out of the responsibility of LHN Boards to promote and ensure psychosocial health and wellbeing in the workplaces for which the Boards are responsible'.

'The amendments bring LHN Boards into line with their corporate counterparts by bringing clarity and balance to their imperatives – not only the need to provide good quality health care and to maintain budgets, but also to care for their greatest asset: their workforce,' he says.

AMA(SA) Culture and Bullying Summit keynote speaker Professor Michelle Tuckey

As a result, the Bill now reads that each Board, which reports to the SA Health Chief Executive, is responsible for ensuring that a hospital in its jurisdiction:

(i) promotes a healthy workforce culture for and among staff employed to work within the incorporated hospital; and

(ii) implements measures to provide for and promote the health, safety and wellbeing of those staff within the workplace (including the psychosocial health, safety and wellbeing of staff); and

(iii) implements policies issued by the Chief Executive on workforce health, safety and welfare (including policies on workforce harassment and bullying), so far as those policies apply to the incorporated hospital.

Dr Moy believes this 'tangible result of the Summit' may be a first in Australia; he says AMA President Dr Omar Khorshid is now looking at the South Australian legislation as a template to recommend as a model for other Australian jurisdictions.

He is pleased it has been achieved in a constructive rather than adversarial way, with AMA(SA) working closely with Minister Wade on an idea which may now seem obvious but was not so before the Summit.

'To have support for this key change, particularly from our leaders, is important and appreciated – particularly this year when doctors and staff have gone through so much for their patients."

Meanwhile, Dr Szewczyk and the DiT Committee disseminated their 2020 South Australian HHC survey in November and will have results in early 2021.

Crises management

So much work is yet to be done to combat what the AMA has repeatedly called a 'global health emergency' while climate change joins COVID-19 as a danger for all Australians, writes Dr Ingo Weber.

Dr Ingo Weber

Chances are you are sick of hearing what a 'crazy and unprecedented' year 2020 has been. So, instead, let us ask, what is it that defined this year for you as a health professional?

Just one year ago we were beginning to experience the greatest fires in Australia's recorded history, as well as unprecedented (that word again!) floods and storms affecting so many Australians, with rural Australia being the hardest hit. Billions of Australia's precious wildlife were killed. Some species have become extinct.

Analysis by the Bureau of Meteorology in 2020 showed that 2019 was the hottest year on record for Australia (1.52 degrees Celsius above the 1961-90 average of 21.8C and well above the previous hottest year in 2013 at 1.33C above the average). Nine of the 10 hottest years recorded in Australia have occurred since 2005. The most recent report issued by BOM and CSIRO State of the Climate 2020 further suggests that within 20 years, these extreme temperatures, fires and storms will become the 'new normal'. In the 58 years from 1960 to 2018 there were 24 days where the average maximum temperature across the continent hit 39 degrees or higher. In 2019 alone it was 33 days. Sadly 2019 gave us a taste of what is yet to come. What will be the health impacts on our communities and in particular our rural communities as this situation is set to worsen?

Just as we were recovering from and reflecting on the dreadful environmental disasters, the COVID-19 pandemic hit. Our increasing interference and intrusion into the natural environment is without doubt disturbing the balance and stability of our life support systems.

However, by reflecting on COVID-19 there is also a good news story to be told. We showed the world how well Australia managed the pandemic by listening to the science and public health experts, and by acting early and decisively. Clearly this saved many lives and minimised the damage to our economy

Public health and its medical experts are now being appreciated more than ever before. Further, for better or for worse COVID-19 has disrupted our 'business as usual' approach. This represents a great opportunity for a healthy recovery by dealing with both the climate change and COVID-19 crises at the same time. How? Well, who best to ask than our economists and our health experts? According to them, investing in new renewable and adaptive technologies means we will generate many more net jobs than in the fossil fuel industries, produce cheaper electricity, and avoid air pollution and lower greenhouse emissions in keeping with the Paris Agreement.

Yet Australia has neither a plan nor a commitment on how to get there. This is noted on the international stage, with the UK and the US asking Australia to commit to zero emissions by 2050.

Bizarrely, in regard to COVID-19 we have seen politicians act with vision and leadership based on sound science and health advice. So why not when it comes to our climate crisis? The cost to act on the threat posed by the virus was great. But the cost for not acting would have been far greater. The same is true for our climate crisis; but it extends the cost to countless of generations to come.

For this reason, the AMA, along with Doctors for the Environment Australia (DEA), last year declared the climate crisis a 'global health emergency' – even before the tragic bushfire season commenced. Both organisations are now again calling on the Australian Government to demonstrate leadership through vision and act in a bipartisan way on our climate health crisis. The AMA has also declared support for Zali Steggall's climate Bill, which asks for a clear plan towards zero emissions by 2050 as well as an independent expert climate change commission to recommend policies based on science, independent of political ideology.

AMA Vice-President and AMA(SA) President Dr Chris Moy with Zali Steggall MP, an advocate for Australian Government action to combat climate change

In the health sector, which contributes between seven and 10 per cent of Australia's greenhouse gas emissions, much needs to be done to reduce our own greenhouse emissions to zero. The AMA and DEA are therefore calling on the Australian Government to establish an Australian Sustainability Development Unit to support sustainable practices in healthcare and reduce the sector's own significant emissions. Both organisations are also asking the government to support policies that acknowledge the tremendous health benefits possible through a transition to renewable energy.

By encouraging our policy makers and political leaders to work together and to listen to the science, by outlining the significant health benefits, and by working on reducing our own greenhouse gas emissions in the health sector, the AMA and DEA are demonstrating leadership in order to protect Australian lives now and into the future. We can deal with both the COVID-19 and our climate health challenges at the same time. At the end of 2020, hindsight 20:20 gives us a clear vision for the required future policies. The opportunities are right here right now.

The air we breathe

Research shows bushfire-related pollution has increased healthcare costs, but that South Australia has fared better than the eastern states.

Nicolas Borchers-Arriagada

The health costs associated with air pollution following the 2019-20 bushfire season jumped nearly 70 per cent in South Australia to $35.84 million, a recent study[1] published in the journal *Nature* has found.

Yet the state fared significantly better than in NSW with bushfire-related health costs of $1.07 billion and Victoria with $493 million.

The study by the Menzies Institute for Medical Research at the University of Tasmania calculated a total of nearly $1.95 billion in bushfire smoke-related health costs in Australia during the 2019-20 season, calculated from 1 October 2019 to 31 July 2020. These costs are not usually included in economic analysis of the costs of bushfires.

This was found to be driven by an estimated 429 smoke-related premature deaths with 3,230 hospital admissions for cardiovascular and respiratory disorders and 1,523 emergency attendances for asthma.

Discussing the air quality research following the release of the latest cost data, researcher Nicolas Borchers-Arriagada says the 2019-20 fire season hit the eastern states particularly hard – partly because the more populous states were exposed to extreme pollution for up to several months.

This pollution was a complex and dynamic mix composed of particulate matter and a range of gases such as nitrogen dioxide, carbon monoxide, volatile organic compounds, and polycyclic aromatic hydrocarbons.

The study of health costs builds on work by the same authors published in the *Medical Journal of Australia*[2] earlier this year which estimated population exposure to particulate matter less than 2.5µm in diameter ($PM_{2.5}$) based on publicly available air quality monitoring data during the last quarter of 2019 and the first quarter of 2020 (1 Oct 2019 to 10 Feb 2020).

This research found that in the period between the last quarter of 2019 and first quarter of 2020, population exposure to $PM_{2.5}$ exceeded the 95th percentile of historical daily mean values in the eastern states on 125 of 133 days, on at least one air quality monitoring station within the study area.

The highest population-weighted $PM_{2.5}$ exposure level, 98.5µg/m3 on 14 January 2020, exceeded the national air quality 24-hour standard (25µg/m3) and was more than 14 times the historical population-weighted mean 24-hour $PM_{2.5}$ value of 6.8µg/m3.

'Our findings indicate that the smoke-related health impact was substantial,' the authors concluded.

'Smoke is just one of many problems that will intensify with the increasing frequency and severity of major bushfires associated with climate change. Expanded and diversified approaches to bushfire mitigation and adaptation to living in an increasingly hot and fire-prone country are urgently needed.'

The authors found concentrations of fire-related air pollution this season were well in excess of any of the previous 19 seasons and the 2019-20 smoke-related health costs were unprecedented in magnitude: more than nine times higher

than the median of the previous 19 seasons of $211 million.

The bushfire health costs research found Canberra's smoke-related health costs were 48 times the previous year's, while in NSW they were up by nine times and in Victoria three times the previous year's costs.

'We looked at the costs associated with mortality related to bushfire smoke, hospitalisation for cardiovascular or respiratory problems, emergency department presentations from October 2000, and there are obviously many more smoke-related health impacts that we didn't account for,' Mr Borchers-Arriagada says.

'For example, during extended smoky periods, work productivity was likely affected, and this could have had a relevant impact in the Australian economy.'

The study did not include the premature mortality associated with the bushfire contribution to annual average air pollution, which is much greater than that associated with short-term daily fluctuations in air pollution.

'For these reasons, the health and economic assessments we present are likely to be an underestimate of the true burden,' the study notes.

However, the report acknowledges that those at greatest risk of death from short-term smoke exposure are likely to have pre-existing diseases and potentially a shorter life expectancy than the average for others of the same age.

While the 2019-20 bushfires took a terrible toll in South Australia with the loss of three lives, 196 homes, 660 vehicles and $200 million of agricultural production, the estimated health costs of pollution associated with bushfires in 2019-20 in South Australia were not as great as those in 2002 and 2009; then the health costs reached $35 million and $38.19 million respectively.

'Maybe there were a few days that were really bad but when you look over a few months and in comparison to other years since 2000, the exposure to $PM_{2.5}$ was not as significant as with previous fire seasons in South Australia,' Mr Borchers-Arriagada says.

'You could also say that this fire season wasn't so bad in South Australia in terms of health costs partly due to its lower population in comparison to the eastern states and possibly the environmental conditions that might have played a role in dispersing the smoke.'

Air pollution generally returns to normal gradually after a smoky episode, with the wind and in the case of South Australia, air pollution was pretty good at about 8 micrograms on average, he says.

However, if South Australia is exposed to prescribed burning or more bushfires there is a potentially high risk in the future – the east coast shows the potential impacts of air pollution on health and its related costs, Mr Borchers-Arriagada suggests.

'Air pollution research shows that exposure has a chronic effect in the long term including lower life expectancy, but in this case we are talking about acute exposure (that's sub-daily to weeks). In general, we haven't been exposed to many events with these levels of pollution exposure.

'If you think about what happens with normal urban air pollution, and the expected increase in magnitude and frequency of natural disasters including extreme fires, I would think there would be some lasting health effects.'

Studies of the impact of air pollution on large populations from tropical deforestation fires in southeast Asia have shown significant health impacts – and that this form of pollution is transnational. Equally, air pollution from the Australian bushfires during the 2019-20 fire season affected air quality in New Zealand and plumes were observed travelling through the southern hemisphere.

Managing wildfire smoke is thus a global policy challenge that requires multiple strategies ranging from global climate stabilisation through to local-scale fuel management, the report says.

Johnston, F.H., Borchers-Arriagada, N., Morgan, G.G. et al. Unprecedented health costs of smoke-related $PM_{2.5}$ from the 2019–20 Australian megafires. Nat Sustain (2020). https://doi.org/10.1038/s41893-020-00610-5, 21 Sept 2020

[1] *Nicolas Borchers-Arriagada, Andrew J Palmer, David MJS Bowman, Geoffrey G Morgan, Bin B Jalaludin and Fay H Johnston*

[2] *Unprecedented Smoke-related Health Burden Associated with the 2019-20 Bushfires in Eastern Australia, iMed J Aust 2020; 213 (6): 282-283. || doi: 10.5694/mja2.50545 Published online: 23 March 2020*

Burned landscape near Woodside in the Adelaide Hills

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A year to stand up

Australia's doctors will remember 2020 as a unique time in our careers, writes AMA(SA) President Dr Chris Moy.

As the year began, in among the terrible stories of bushfires across the nation, we first heard the murmurings of an infectious condition caused by an agent termed a 'coronavirus' that had started to cause deaths in Wuhan, China.

Within days, I was one of the many doctors, administrators and policy-makers developing and disseminating carefully worded statements about how Australians who had recently been to Hubei Province should monitor symptoms and, depending on their contacts, isolate. In South Australia, the AMA drafted our first media release about the 'Novel Coronavirus' over the Australia Day weekend.

How long ago that seems. And how much has changed. I think it's fair to say no one would have believed in late January that what would quickly become internationally known as COVID-19 would change everything about how we live and work, in Australia and around the world. No one could have imagined what would be required of us as individuals; as students and educators; as health practitioners, staff members and employers; as colleagues, family members and friends. No one could have predicted that a virus with that innocent descriptor 'novel' could in a few months wreak so much havoc on people's lives, businesses, and economic and social security. No one could have known that my reference to 'uncertainty and confusion' in that first media release would continue to influence our mental health and wellbeing as we approach Christmas.

How wrong I was, and here we are. And, of course, it is not even close to being over. But the end of the year provides a milestone from which to remember that while there has been so much trauma and tragedy, we have all learned many lessons; reflect on our experiences; and recognise what has been achieved along the way.

At a state level, I believe that the strong position we are in now is due to two factors. First and foremost, we have followed the science, and we have followed the people who have followed the science. From the Premier and Commissioner Grant Stevens to those of us going to work and school, visiting supermarkets and walking our dogs, we have been willing to accept and adhere to policies based on the evidence evaluated and presented by Professor Nicola Spurrier and her team. Second – and this flows on from the first – we have largely accepted that to follow the evidence will be best for all of us. We haven't been swayed by conflicting calls to 'put the economy first'. And it is now unequivocal that by putting health first and eliminating the virus, we are in fact in the best place to survive and recover economically.

Nationally, too, the AMA has been central to the creation and dissemination of sensible, science-based decision-making. Our advice has been sought by governments and communities, as well as our members and other health practitioners and administrators.

Throughout the year, and even now, we have fought for the most appropriate, safe personal protective equipment for health workers. And every day, often many times a day, journalists asked AMA members for explanations, comments and advice to help our country and its people navigate the 'uncertainty and confusion' that exists even now.

Six weeks after we prepared that first media release, and two weeks before South Australia's first lockdown began, I penned an opinion piece for local media. In it, I implored that South Australians think about each other and be kind; that we look beyond our individual needs and instead show the spirit of generosity, bravery and big-heartedness that was so evident during and after the summer's bushfires.

I think we have done just that. In the face of a once-in-a-lifetime threat, we have pulled together and looked after each other. And I'm so very proud to have been a part of the AMA as an incredibly important contributor to where we are today.

Medicine is a high calling

The pandemic has forced us all to look at life, ourselves and our chosen profession differently, writes Doctors' Health SA and NT's Dr Roger Sexton.

Our training is long and arduous. We sacrifice a lot to reach the point of Fellowship and to commit to life-long learning and the service of others. Only we, as doctors truly understand this.

We acquire such skills as leadership, calmness in a crisis, strong emotional intelligence, pattern recognition and the judicious application of a 'tincture of time'. We learn pragmatism and the satisfaction of achieving clear and measurable clinical outcomes for patients.

We learn how to adapt, calmly lead and cope when there is a professional emergency, and this influences our personal response to external shocks such as COVID-19. We have expectations of ourselves that as trained doctors, we will handle it.

But COVID-19 'got personal'.

We found ourselves as community members sharing the same concerns as others about family, safety, mental health, income and the future.

Our responses at home may have been more subdued or more intensified by our knowledge and training.

Our work in complex health systems is exposing us to diverse workplaces and work practices. Some of these are quite unhealthy and require us to individually adapt. It is unusual to hear of workplaces that adapt to our needs.

We also carry a large work burden and are expected by others to handle this. We are seen as professionally well-resourced and supported. This can deny doctors permission to express their struggle and share how much burden, COVID-19 included, they are carrying each day.

Doctors are typically reluctant to ask for external assistance when the road becomes difficult and corrugated, preferring to privately sort problems out by ourselves. When help is eventually needed, it can be difficult to find.

Since the profession established Doctors Health SA in 2010, our team of doctors has seen over 1100 doctors and students from all craft groups and heard their stories and offered acute crisis intervention.

COVID-19 has markedly increased our engagement with doctors at this time and at Doctors' Health SA we have seen a range of personal and professional reactions to COVID-19.

Doctors are mostly gregarious and prefer human contact to working from home. We have seen doctors forced into isolation away from their usual social musters and the social aspect of their workplaces with patients and staff.

The cancellation of elective surgery triggered by COVID-19 restrictions exposed the lack of preparedness and financial vulnerability of some doctors who were operating as highly leveraged individuals and on the basis that cash flow would remain continuously positive.

At the same time, COVID-19 has offered some over-committed doctors permission to step back from the many roles that have been fulfilling, and to take a breather.

Doctors' Health SA sees many burdened doctors with extraordinary capacity to work across many roles, provided they are well. There is little opportunity however, to step back voluntarily from these even though many would like to do so!

COVID-19 cleared our diaries of dinners, events and meetings and other commitments. This has been welcomed by many doctors who were over-committed and unable to voluntarily step back.

And then there is the professional toll that the pandemic has taken. COVID-19 has added to the long list of work, health and safety hazards to which doctors are exposed. Examples are:

- unsafe work hours
- physical violence
- fatigue
- burnout
- information and website overload
- easy access to medications
- infectious diseases (including COVID-19).

Doctors in Training and service registrars seeking entry into specialist training programs experienced COVID-19 interruptions that have stalled their career aspirations and extended their wait and training by another year.

COVID-19 has exposed the infrastructure of some clinics as not 'fit-for-purpose' and ill-suited to meet the future expectations of patients in the new infectious environment.

The stress of implementing COVID-19 protocols in consulting clinics has been significant and required such changes as disposal of furniture and new protocols to safely streamline patients into and out of clinics.

Doctors using telehealth report:

- 65 per cent of GPs have had medico-legal concerns about having to work in an unfamiliar way with social distancing in the consulting rooms, using telehealth and consulting from cars in the carpark or drive-through clinics.
- 80 per cent of doctors have expressed their fear of bringing COVID-19 home to family members.

Rural doctors working remotely in vulnerable Indigenous communities have been expected to lead and hold a functional clinical team together, often as other clinical and support staff have frequently come and gone. They have been trapped in remote and interstate places unable to be with family and where the requirement to quarantine twice made escape tedious and pointless.

As valued members of a key essential services profession during COVID-19, we have been trusted above all others to advise patients and guide politicians and law enforcement agencies in their highly consequential financial and societal decision-making.

We have all reacted to COVID-19 as social individuals and professionals working in the health system. We have all managed this differently and experienced a variable impact.

It has reminded us we have:

- a need for a social life alongside medicine
- permission to pause periodically and take a step back to examine the burden we are carrying
- a society who values medical leadership and our contribution as medical practitioners
- momentum in the health system hierarchy.

These are things to enjoy and celebrate.

Dr Roger Sexton is the medical director of Doctors' Health SA and NT and deputy chair of MIGA.

Self-care replaces holidays during COVID-19

COVID-19 threatened the viability of many private medical practices, but most seem to be bouncing back, says AMA(SA) Councillor Dr Edward Greenrod.

Like many other private practices, Dr Edward Greenrod says, ophthalmology practices such as his had to rapidly adjust to the challenge of providing telehealth where possible – even though most of their work typically requires face-to-face patient assessments.

Having access to Medicare numbers for telehealth and telephone consultations greatly helped provide continuity of care and reassurance to patients during the pandemic, even where it was impossible or not appropriate to schedule a face-to-face appointment, he says.

'For about two months most practices in our field were using phone consultations when it was possible, which was a totally new situation for many of us,' Dr Greenrod says. 'We barely ever use telehealth consultations in ophthalmology – examining and assessing eye patients is typically very reliant on visual assessment with the slit lamp and other diagnostic technology in the rooms.

'Although assessing patients over the phone was quite limited for us, patients really appreciated the simple verbal contact and reassurance. What was also quite surprising was that, in some situations, patients could take great photos of their eye with their smartphone camera, and the quality of image was so good that they were actually very useful to help triage a number of conditions such as red eyes or eyelid problems.'

As with other specialties, ophthalmology practices limited their face-to-face consulting to emergency conditions and those conditions needing time-critical treatment or surgery – overall, comprising a relatively small proportion of ophthalmic presentations.

State-wide restrictions on elective surgery also meant surgeons and anaesthetists performed a fraction of their usual surgical caseload for a considerable time, as hospitals conserved their personal protective equipment (PPE) to prepare for and manage COVID-19 requirements.

'Early on, the greatest worry for all of us was that patients would simply avoid healthcare during the pandemic, which would result in a wave of missed diagnoses or late presentations of sight-threatening eye disease,' Dr Greenrod says.

'Some patients did seem very scared early on and cancelled their scheduled appointments. For those patients who needed scheduled regular treatment to protect their sight, that was the worry.'

Yet, he says, the initial worries about missed eye care appear not to have eventuated.

'I suspect that overall, across South Australia, there may have been some delay for patients making their follow-up appointments or seeking care,' Dr Greenrod says.

'However, at least from our own experience, we haven't seen any patients who've missed their appointment or treatment and suffered as a result.

'Since the initial COVID wave flattened out in South Australia, a considerable number of our older patients have told us that looking after their health had become their new focus.

'We've seen patients who have finally got around to scheduling themselves for their specialist appointment or the elective procedure that they had been putting off. This has been reassuring to see, both in the sense that patients are prioritising their health even during uncertain times and that private practices still have an important role to play in providing services during the COVID era.'

Dr Greenrod says the other major challenge for private practices during 2020 has been ensuring the emotional and physical wellbeing of staff. Early on, there was the constant challenge of sourcing adequate supplies of PPE, hand sanitiser and isopropyl alcohol surface wipes, which was 'just stressful' for everyone, Dr Greenrod says. Practice staff also had understandable concerns about job security for themselves and their family members and for some there was a degree of fear about potential exposure to COVID from contact with members of the public.

'It's easy for us to forget now just how new all of the processes and procedures were for staff,' he says. 'This became a real focus for us at our own practice, to ensure staff were feeling supported during the early period and keeping regular communication open.

'During the slower weeks, the practice also took the opportunity to catch up on procedural administration, including reviewing our audits and policies.'

While COVID cast a shadow over most areas of the community, he says the additional time and opportunity to focus on personal connections were the 'silver lining' for private practice.

'Good medical care is all about teamwork and relationships are critical in the running of any private practice, so I think it was a great chance for staff to reconnect on a personal level,' Dr Greenrod says. 'It was impressive also to see how so many of our staff put in the extra time and effort to ensure patient care was prioritised throughout the entire period.

'The other thing we noticed is that the staff in our practice became a lot closer. We were already close, but it's become a really tight-knit bunch and they really enjoy working with each other – of all the positives during these challenging times, for us that's certainly been one of the greatest.'

A total rethink

South Australian GP Dr Kerry Hancock is one of the thousands of medical practitioners around Australia who has found COVID-19 to have enormous professional and personal costs.

Dr Kerry Hancock

With personal experience of being ventilated with an Acute Respiratory Distress Syndrome illness, and having adult children in London and Melbourne during the COVID-19 lockdowns, it would have been easy for general practitioner (GP) Dr Kerry Hancock to be preoccupied with anxiety throughout 2020.

'I tried to put my own personal anxieties aside during those first few weeks and months,' Dr Hancock says. 'I had a son in London in the UK with a British wife … My other son, his wife and my grandson were in Melbourne and our borders had closed.

'The reality of COVID-19 hit home when my daughter-in-law's grandfather, whom I had sat next to at the wedding less than a year ago, succumbed to COVID-19 and my other son's best friend's father in the UK also died of COVID. My mother was also in a vulnerable age group.

'I just could not even imagine what it would be like to be in an ICU on a ventilator or even unwell in hospital, when there were restrictions on hospital visitation in this COVID time, without the support from family, friends and colleagues as I had when I was unwell. I just tried to not think about it.'

Life in Dr Hancock's Happy Valley practice was frantic as she and her colleagues tried to re-think workflows and procedures to limit potential infections. They mobilised early, meeting to redesign the practice set-up to have one entrance and a separate exit, establish patient and visitor screening questions and sanitiser stations, and secure enough limited personal protective equipment (PPE).

There were meetings at the surgery with partners, other clinicians, administration staff and managers; webinars to share information about the virus and restrictions; meetings with clinicians at the Local Health Network to discuss how and even if patients should attend practices, before other pathways and GP respiratory clinics were in place.

'We were holding Zoom or car park meetings with the clinicians most days of the week and then we would attend webinars a few nights of the to keep up to date with all the new information coming through,' Dr Hancock says.

'Trying to keep everyone on the same "song sheet" was often challenging. Having a very cohesive leadership group – including the practice partners, nurse manager and our business manager – as the conduit to the rest of the practice was crucial.'

Providing between 4,000 and 5,000 'flu vaccinations safely during the pandemic created a logistical puzzle, but the practice rose to the challenge, including spending days at the local retirement village and visiting vulnerable patients at home. The practice's doctors embarked on a vaccination blitz over four Sundays either side of Easter, with strict triaging and social distancing protocols in place.

'We had great feedback from our patients – I think they felt safe and respected,' Dr Hancock says.

Introducing telehealth in the form of telephone consults was viewed as extremely valuable in the short and longer term, but doctors were concerned that they could 'miss' things as they could not see the person. This increased GPs' anxiety; the practice leaders made themselves available to chat with doctors and staff at any time including after hours, she says.

There were so many questions: which platform to use, how to use it, how were privacy issues being resolved, did the patients know how to access and use the various platforms.

'I look back to the first webinar that I had to facilitate in early June and just how much I have learnt about webcasting and webinars and ethernet cables, speed tests and earpods, Dr Hancock says. 'And my neck didn't appreciate all the mobile phone use, even after I purchased some decent earphones.'

While doctors appreciated how quickly the new technology and Medicare item numbers were instituted, she says many found they became 'webinar-ed out' with an overload of digital meetings and service delivery. Continuing Professional Development (CPD) providers were also agile in establishing alternative channels for training – but for some doctors, it just meant more time online.

There was an understandable burst of excitement when face-to-face education events were finally permitted.

Dr Hancock says her practice needed to update its phone system for NBN and add to its five phone lines in addition to the fax and internet lines. The phone rang constantly and the fax machine worked overtime, sending scripts to pharmacies. Other paperwork (such as certificates) needed to be scanned and emailed to patients securely, testing the limits of admin staff. Many doctors tried to consult from home and found that challenging with the burden of scanning and emailing adding to the workload.

Widespread concern in the community, which prevented people from going to the doctor for routine appointments, and costs associated with COVID-proofing the practice added to GPs' pressures.

'I just felt I couldn't take "my eye of the ball" for weeks and months!' Dr Hancock says. 'In retrospect, I was more hypervigilant than I had been since starting in general practice more than 36 years ago. For the first time since residency I felt I could be out of my comfort zone.

'I felt as if I lived, breathed and slept with COVID-19 for those first few months. But I was OK physically and mentally and I knew that I had good support around me.'

She says that as a doctor, the toughest aspect was dealing with the uncertainty around the science – just as it had been in the early days with other diseases such as HIV/AIDS.

'I had a patient who developed COVID-19 in the third week of March,' she recalls. 'At that stage, the specialised GP service had not quite been established,

so I needed to review her via phone and then face-to-face as she was recovering.

'I was needing to check the guidelines all the time so it was great that we had SoNGs to refer to, as well as the GP Liaison at SA Health.'

Keeping the team safe and happy remained a constant challenge, with often overwhelming information coming from all directions – from SA Health, the Communicable Disease Control Branch, the Royal Australian College of General Practitioners, the AMA and South Australia Police.

And, while the testing regime was a feather in South Australia's cap, Dr Hancock says it came at a cost.

'There always seemed to be a doctor or nurse or an admin staff or two away because they were either being tested themselves and waiting on a result, or looking after someone waiting for a result, putting pressure on the workload for the day.'

Some lasting lessons have emerged from the COVID-19 experience, particularly in relation to infection prevention and control, including social distancing, cough etiquette, hand washing, staying away from children with upper respiratory tract infections, and especially staying home and away from work, public transport and school and the shops when you have a viral infection.

There is also an accumulation of knowledge about what to do differently 'next time' – including having a steady supply of PPE, measures to accelerate testing to reduce wait times, and systems and practices to protect residents in aged care facilities while keeping them connected to family and friends. She also praises the cooperation between the public and private sectors, with valuable systems established such as the GP Liaison in the Coordinating Centre.

If nothing else, Dr Hancock's team has learnt quite a bit about each other – such as who has politically incorrect Zoom pseudonyms or background pictures – and who is up with the latest lingo; certainly not the colleague who was repeatedly heard telling amused colleagues to 'check their junk' [slang for genitalia] instead of check their junk email.

'We were also kept amused (and informed) by our usual weekly staff newsletter wondering what funny cartoon our business manager would come up with each week – always one for us in Adelaide and one for our Seattle-based GP colleague and friend who is still part of our practice, despite being isolated on the other side of the world,' Dr Hancock says.

'With the events in America you can imagine that there was a lot of fodder for some very entertaining cartoons and memes.'

Chandlers Hill Surgery nurse manager Casey Franchi and operations manager Meera Simon consider systems to protect staff and patients during the pandemic.

Towns and country

It's been a rollercoaster of a year, professionally and emotionally, writes 2019 RACGP National GP of the Year and new AMA member Dr David Lam.

Dr Lam outside Cleve Hospital with University of Adelaide medical students Ellie Schofield and Bianca Melzner

'I just want all people living in Australia to be safe and healthy, regardless of age, race, gender, beliefs or postcode.' As a Hakka (客家)Chinese Australian doctor, this was my response when asked what winning the RACGP National General Practitioner of the Year Award in 2019 and being named in the 2020 InDaily 40 Under 40 list meant to me. Despite the challenges of 2020, rural South Australians have united and looked after each other through bushfires and then the COVID-19 pandemic. We are still looking to innovate, improve and level the playing field between health care in rural and remote areas compared to our metropolitan equivalents.

COVID-19 aside, healthcare in South Australia will always be plagued by the tyranny of distance. I live and work in Port Lincoln, 650 km away from Adelaide. This means I am 650 km away from the nearest intensive care unit, cardiac suite and psychiatric ward. Patients are frequently transferred to Adelaide by air with life-threatening conditions; as a Port Lincoln doctor you often must do what you can until more help arrives. For example, patients presenting with severe mental illness requiring an inpatient treatment order are also required to undergo chemical sedation and air transfer to Adelaide. As the treating doctors, we must take into consideration risks never contemplated as metropolitan doctors, such as, 'Is this patient more at risk right now of their mental illness if I don't involuntarily admit them or more at risk from iatrogenic harm and the inevitable anaesthetic risks if I do detain, sedate and transfer them?'.

Port Lincoln is therefore not an easy job. We are required to treat patients not just in our general practices but also when they present to Port Lincoln Hospital emergency department requiring life-saving care. No matter how good you are, you just cannot safely be in two places at once. This sadly translates into a perpetuating cycle of suboptimal primary care. If I am suddenly called away from a clinic full of patients for the next four hours to deal with a patient in the emergency department having a heart attack, any one of these patients in my waiting room could deteriorate into next month's heart attack because their appointment was cancelled and opportunities for preventative care were lost. 2020 was even harder due to bushfires and COVID-19. There was a spike in mental health issues relating to financial hardship, businesses closing and mandatory isolation from friends and family. Cancellation of elective procedures and postponement of 'routine health check ups' impacted heavily on the quality of life and the preventative care of patients. Logistically, COVID-19 also hurt us by creating barriers for urgent medical transfers to Adelaide and disrupting the flow of help coming from interstate locums, upon which the small country towns of South Australia are so very reliant.

Dr Lam being presented the InDaily 2020 40 Under 40 award by Adelaide entrepreneur David Rohrsheim

Recruitment and retention remain two huge challenges for the rural workforce and patients alike. The problem is multi-factorial, but solutions must surely begin with the simple notion of 'grab them while they are young'. Cadetships and youth development programs are a tried and true strategy of the vast majority of successful companies and sporting clubs. Doctors leaving their country towns after short periods of service is a problem commonly attributed to sustained isolation from their partners and families, who often remain in metropolitan Adelaide for careers or schooling. We must therefore strive to expose medical students and junior doctors to rural practice as early as possible in their careers, while they are still flexible without mortgages or masses of family commitments in Adelaide.

I came to Port Lincoln as a medical student of the Adelaide Rural Clinical School. I was so fascinated by the vast scope of practice that I volunteered to return as a GP Registrar and then elected to remain serving this community after completing my fellowship. It is an honour to now be working with the Adelaide Rural Clinical School as its Rural Medicine Coordinator, teaching all 42 University of Adelaide medical students placed in rural South Australia on a weekly basis. It was also wonderful as a GP registrar supervisor to see our registrars, James Ashby and Keith Jarrett, successfully pass their exams and also choose to remain serving Port Lincoln after Fellowship.

COVID-19 has meant we have had to be creative with medical training. This year I had to convert my tutorials into a free podcast called 'GP Lyf Hacks' to make up for the cancellation of face-to-face teaching with our registrars. To minimise risk of spread, medical students were offered long placements at a single rural practice. Two standout final-year students, Ellie Schofield and Bianca Melzner, were instrumental in their service to the region, assisting me with outreach trips to surrounding towns without a regular medical service and presenting clinical cases with me at the RACGP National Rural Forum.

The pandemic and forced closure of state borders has also unfortunately highlighted how many South Australian towns are reliant on interstate locums. Twelve months ago, a *medicSA* article outlined the hardships faced by the Eyre Peninsula town of Streaky Bay, which had remained doctorless for a protracted period. This year, Dr Victoria Bradley thankfully assumed the role of Streaky Bay's regular GP. Jonas Woolford, Chair of the Streaky Bay Medical Clinic Board, has worked hard to implement a plan in which I visit regularly from neighbouring Port Lincoln to provide vital assistance to Dr Bradley, who would otherwise be the sole GP in a remote town unsustainably on call 24/7. Cleve, Cowell, Kimba and Elliston were also depicted in the article as Eyre Peninsula towns separated by hundreds of kilometres run tenuously as a single model/entity by the Eyre and Far North Local Health Network (EFN LHN). These four towns are diligently managed by three local doctors taking it in turns to be on-call for all four towns simultaneously. But with so few of them, taking leave is exceedingly difficult. During the pandemic, these towns used coverage by Dr Graham Fleming from neighbouring Tumby Bay, and me, to support their doctors. In a unique effort to promote awareness and recruit for this struggling region, I brought my medical students, Ellie and Bianca, with me to gain experience in these towns. However, now that borders have reopened, the EFN LHN has elected to resume service from interstate doctors rather than local doctors from neighbouring towns with invaluable familiarity of local services and resources.

2020 has certainly been a challenging year, all the more so in the provision of healthcare in rural South Australia. The workforce is depleted but hopefully the strength of country people combined with innovations in IT and teaching and training will create a sustainable health system for all Australians, regardless of their postcodes.

Dr Lam at Streaky Bay

An anxious wait

Early findings indicate serious impacts of the pandemic on mental health, but no increase in the suicide rate - yet.

Anecdotally, mental health – especially among younger people – has been a casualty of COVID-19.

The Adelaide Suicide Prevention Service run by AnglicareSA has reported being overrun by demand for services just after the COVID-19 lockdown and while numbers stabilised in August/September, the service expects Christmas pressures to precipitate more suicide attempts.

Yet at this stage, rigorous data on the impact of the pandemic on mental health is limited, pointing to the need for more research to form the basis of appropriate resource allocations in coming months.

The Australian Institute of Health and Welfare (AIHW) notes that while there has been a rise in the use of mental health services, there is no clear evidence that COVID-19 has been associated with a rise in the suspected suicide rate, self-harm, suicidal behaviour or suicidal thoughts.

Modelling by Australian National University suggests this may in part be due to the JobKeeper and JobSeeker payments that led to many people reporting they were in better financial positions while they received these payments than they had been before the pandemic.

The AIHW found notable rises in the use of crisis lines and mental health services since the onset of the COVID-19 pandemic, with calls to Lifeline between 10 August and 6 September 2020 increasing by 15.3 per cent compared with the same time in 2019.

Contacts to Beyond Blue increased by 38.6 per cent and calls to the Kids Helpline by 24.5 per cent over the same period.

'It is not clear to what extent this rise in contacts is driven by rises in psychological distress rather than a higher proportion of people seeking assistance for other reasons such as loneliness and concern about contracting COVID-19,' the AIHW said.

Demand for Medicare-subsidised and telehealth mental health services also increased. The total number of mental-health-related MBS services in the four weeks to 6 September was 12.5 per cent higher than the equivalent period in 2019 – and 20 per cent higher in Victoria than in other jurisdictions.

A recent Australian study in *Frontiers in Psychology* found that depression and anxiety levels were significantly elevated in people with no previous mental health diagnosis, compared to previous population data.

The study was the first to survey a representative sample from the Australian population at the early acute phase of the COVID-19 pandemic. Depression, anxiety, and psychological wellbeing were measured with well-validated scales (PHQ-9, GAD-7, WHO-5).

The study tested for associations between mental health and exposure to COVID-19, impacts of COVID-19 on work and social functioning, and socio-demographic factors.

It found that the disruption to work and social conditions caused by the pandemic were strongly associated with elevated depression and anxiety symptoms, as well as decreased psychological wellbeing. Financial distress due to the pandemic, rather than job loss per se, was also correlated with poorer mental health.

Direct exposure to COVID-19 or the recent bushfires was not correlated with elevated levels of anxiety and depression although exposure to bushfire smoke was correlated with reduced psychological wellbeing.

The report's authors said innovative and creative policy measures were required to minimise disruption to work and social functioning and increase access to mental health services in the community.

While previous studies of the effects of pandemics (such as SARS and Ebola) on mental health focused on the mental health of disease survivors, this study examined the mental health impacts of the COVID-19 pandemic on the broader population.

It surveyed a representative sample of Australians from 28 to 31 March 2020, during the acute phase of the pandemic in Australia.

Mental health issues in Australia had just started to escalate. In the previous fortnight, the Australian government had closed restaurants, bars, and churches; severely restricted the size of public and private gatherings; and banned foreign nationals from entering Australia; and was enforcing strict quarantine measures for Australians returning from overseas.

The study measured the prevalence of clinically significant symptoms of anxiety and depression and measured association with other recent adversities. It also considered the degree to which symptom severity was associated with exposure to COVID-19 and the impact of the pandemic on the person's financial and social circumstances.

The study found the social, work, and financial disruptions associated with the acute phase of the COVID-19 pandemic impaired community mental health in Australian adults.

Exposure to COVID-19 was not found to predict mental health in this cohort; neither was being required to work from home associated with any mental health effects at the acute stage of the pandemic.

'Our results suggest that, at a population level, changes to social and work functioning due to COVID-19 were more strongly associated with decrements in mental health than amount of disease contact. This finding is consistent with a recent UK-based finding that their citizens were more concerned about how societal changes will impact their psychological and financial wellbeing, than becoming unwell with the virus,' the authors said.

The finding also aligned with emergent work indicating that loneliness is playing a central role in the observed mental health impacts of the COVID-19 pandemic.

Escalating psychological distress associated with the pandemic pointed to a likely rise in demand for mental health services which would also be stretched by social distancing requirements and would need to be delivered flexibly, the authors noted.

The findings also suggest the need for policy responses to the pandemic to minimise financial and social disruption.

'Our results suggest policy approaches that target financial support to those

experiencing financial strain may be useful, rather than on the basis of lost employment alone. We also found that well-established risk factors for poorer mental health—younger age, identifying as female, and having a pre-existing mental health condition—continue to be associated with increased risk within the pandemic context.

'Governments should consider additional measures to monitor and support these at-risk groups,' the authors said.

Family and domestic violence (FDV) is also a major concern related to deteriorating mental health during the pandemic. In its submission to the House of Representatives Standing Committee Inquiry into Family, Domestic and Sexual Violence in July 2020, the AMA said:

> *Natural disasters and pandemics are associated with a number of risk factors for FDV. These include higher levels of financial uncertainty and insecurity; psychological distress; and higher consumption of alcohol and other drugs – all of which have increased in the first half of 2020.*

The AMA noted:

- Australian Institute of Criminology research showing that among women who reported they had experienced physical or sexual violence from an intimate partner in the last three months, two-thirds reported that the violence had started or escalated since the start of the COVID-19 pandemic
- St Vincent's Hospital in Melbourne reported a doubling in domestic violence-related presentations in the first quarter of 2020, compared to figures in the same period in 2019
- 1800 RESPECT reported a 38 per cent increase in the use of its online chat tool for sexual assault, domestic and family violence counselling between March and April
- the NSW Bureau of Crime Statistics and Research reported an overall 4.1 per cent increase in domestic violence incidents over the last two years, with anecdotal evidence suggesting a significant increase in demand for FDV services from March-May of this year
- surveys conducted by Monash Research in Victoria and Queensland with FDV service providers, including those in the healthcare sector, found that providers were experiencing significant increases in demand as well as more complex cases since the outbreak of COVID-19
- of surveyed frontline workers in Aboriginal and Torres Strait Islander FDV services in NSW, 44 per cent reported an increase in client numbers and 56 per cent reported an increase in case complexity since the beginning of the COVID-19 pandemic.

Recommendations from the AMA included:

- funding for flexible support packages to make it easier for victim survivors in financial distress to access support and improve their safety
- funding for longer-term affordable and safe housing for victim survivors and their children
- funding for specialised support for women in vulnerable groups
- appropriate resources to support adequate implementation planning and performance measurement of any new funding
- targeted support for frontline workers, including medical professionals, on the unique effects of the bushfire season and COVID-19 on FDV, including advice on how best to engage with victim survivors.

[1] *R Digirolamo, Demand spikes for suicide help, The Advertiser, December 1, 2020, p 16.*

[2] *Australian Institute of Health and Welfare, The use of mental health services, psychological distress, loneliness, suicide, ambulance attendance and COVID-19, https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19, 17 November 2020.*

[3] *Amy Dawel, Yiyun Shou, Michael Smithson, Nicolas Cherbuin, Michelle Banfield, Alison L. Calear, Louise M. Farrer, Darren Gray, Amelia Gulliver, Tambri Housen, Sonia M. McCallum, Alyssa R. Morse3, Kristen Murray1, Eryn Newman, Rachael M. Rodney Harris 5 and Philip J. Batterham3, The Effect of COVID-19 on the Mental Health and Wellbeing on a Representative Sample of Australian Adults, Frontiers in Psychology,: 06 October 2020,doi: 10.3389/f psyt.2020.579985.*

STOP PRESS

Scholarship winner to help remote communities

A physiotherapist who switched to medicine after seeing the needs of remote Aboriginal communities has been awarded the 2020 AMA Indigenous Medical Scholarship.

Lloyd Diggins, now in his third year as a medical student at the University of Notre Dame Australia, is currently working in Kununurra as part of the Rural Clinical School of Western Australia.

Mr Diggins, 29, is a Wongi Aboriginal man from Western Australia who became determined to make a difference, having witnessed the overrepresentation of Indigenous people in the health system while working as a hospital physiotherapist in Perth.

Discouraged from combining his culture with his work, and frustrated by racist experiences, he moved to Darwin on the advice of his sister who was providing healthcare with a cultural focus.

Working at the allied health service at Gove District Hospital in East Arnhem Land, Mr Diggins discovered the area needed another GP.

'I had fallen in love with the Yolngu people and the Gove region, and I thought that if I was going to live in Arnhem Land for the rest of my career, I ought to "duck into town" and pick up a degree that would let me provide the type of help that the local people needed,' Mr Diggins says.

Mr Diggins has continued to work for WA Country Health Service alongside his immediate and extended family while completing his medical studies.

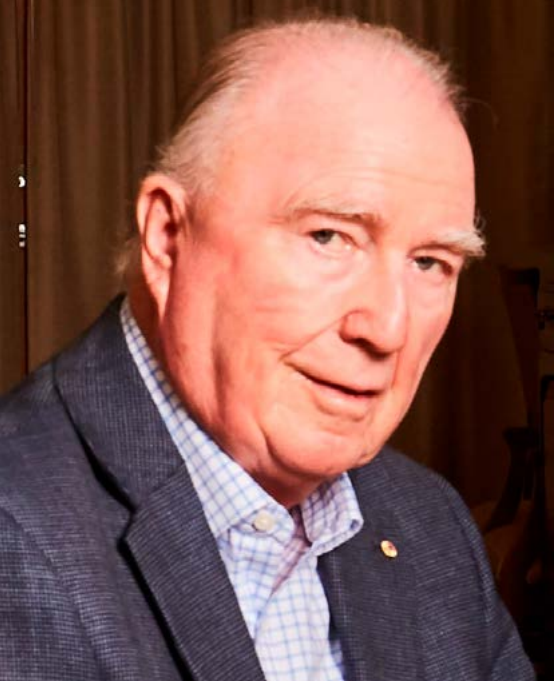
'I have seen how a lack of palliative care and dialysis in rural and remote areas is devastating to Aboriginal people, who are dying away from their country and their families,' he says.

Mr Diggins eventually hopes to develop a formalised Aboriginal medicine training program for future students.

AMA President Dr Omar Khorshid has described Mr Diggins as an exceptional young man with a real gift for making those around him feel listened to and valued.

'At the end of 2019, there were just over 600 Indigenous doctors in the medical workforce, which is about 0.5 per cent of the workforce,' Dr Khorshid says. 'This is a slight improvement on previous years, but to reach population parity of 3 per cent the number should be closer to 3,600.

The AMA Indigenous Medical Scholarship was established in 1994 with a contribution from the Commonwealth Government. Donations are tax-deductible and can be made online here.



Emeritus Professor Peter McDonald

Clusters, cleaning and contamination

History suggests we should start mapping an exit strategy from the pandemic, says Flinders University's Emeritus Professor and infectious disease (ID) physician Peter McDonald AM.

As nations the world over are grappling with possible new strains or clusters of COVID-19, policy makers are faced with tough choices about balancing risks and easing restrictions.

It will be vital to look to science and public health rather than political expediency to avoid fear, says infectious disease physician Professor Peter McDonald, who chaired the National Health and Medical Research Council (NHMRC) committee that wrote Australia's first national infection control guidelines in the 1980s.

The Parafield cluster and evidence surrounding transmission within close contacts and the broader community highlighted important issues around the likely evolution of the virus and how to manage it, Professor McDonald says.

'The history of pandemics shows viruses tend to evolve … From what we are seeing overseas, it seems that the virus is evolving,' he says.

'It's becoming more easily transmissible, but many of the people who get it are younger and asymptomatic, which makes it very difficult for contact tracing.

'The recent brief lock-down in South Australia illustrates important factors about the virus and the challenges that authorities and the medical community face in managing the on-going pandemic. The Parafield cluster raised the question about whether there is a new cluster of a more highly transmissible virus that could have been imported.

'We can see from historical observations of past pandemics and from the experience overseas that viruses become less pathogenic as the virus adapts to surviving in human hosts after crossing from another species.

'A virus is always more pathogenic in the new host after it has jumped from another species. But the virus evolves and adapts. It becomes less pathogenic – if it kills its host it cannot persist in the host population.

'It appears that the transmission rate is increasing while the virus is becoming less pathogenic.'

Professor McDonald says the South Australian Government, SA Health and the community had responded rapidly to the community transmission when it was first detected in an elderly patient in an emergency room. Cooperation was widespread, with levels of testing, quarantine and contact tracing boosting the precautions taken by people in their homes and public places.

'One of the most interesting aspects of the sudden call for lockdown was the claim that this was a new cluster, highly transmissible and consistent with a UK strain being imported with a returning citizen,' he says. 'Even more interesting was the fact that this particular strain was transmitted to other quarantining guests in the medi-hotel, raising issues about how this transmission could have occurred in a "controlled" environment.'

He says 30 years of managing cross-infection in hospitals had shown the need for strict, universally adopted infection control practices, including staff behaviours such as handwashing, use of personal protective equipment and cleaning the environment.

'Sensibly, the authorities have decided to move all positive cases to a hospital environment where control of transmission is vastly better than in a hotel,' he says.

'We've known for a long time that fabrics like carpets, upholstery fabrics and drapes harbour human "contamination" and are difficult and expensive to sterilise and clean.

'I observed this in managing staph infections in the 1970s. When the environment becomes heavily contaminated, that's when you get lots of people becoming infected with the same strain as they touch drapes and benches as well as transmitting infection person-to-person.'

Professor McDonald says it is difficult to begin considering an 'exit strategy' when authorities are forced to manage emerging cases. Selecting the ideal time to start talking about a de-escalation of restrictions remains a challenge for policy-makers – particularly in the absence of a unified national approach, such as the one that underpinned the response to HIV/AIDS.

However, he says, now might be time for the organisations such as the AMA to discuss with policy makers a strategy to emerge from the pandemic – 'one based on science rather than politics'.

Despite rising optimism about the likelihood of a successful vaccine becoming available in 2021, Professor McDonald says policy makers must await the outcome of vaccination before going too far in relaxing restrictions.

'We do need to keep our powder dry until vaccines are tested in greater numbers,' he warns. 'In the end, a vaccine is going to be important for COVID-19 in the same way it is for influenza.

'Doubtless they are going to vaccinate large numbers of people, but it remains conjectural to say that it is going to save the situation. We must start providing people with information about how the infection evolves and incorporate this into planning the strategy for relaxing restrictions.'

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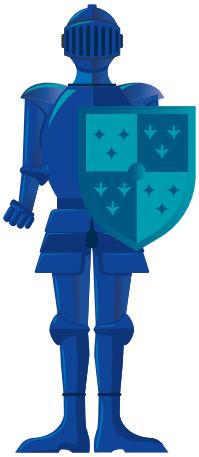
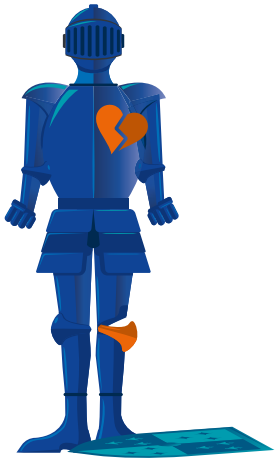
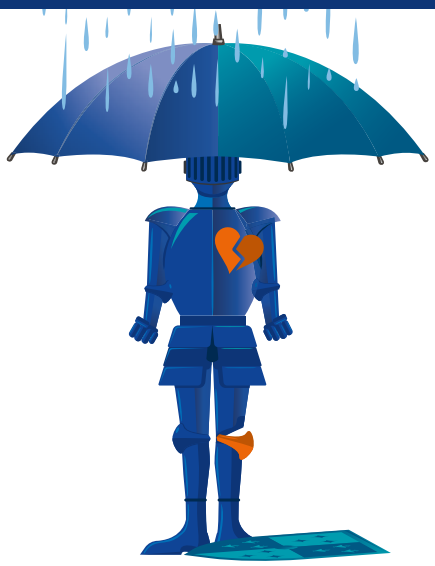


When we're young we tend to think we're unbreakable, bulletproof.



It's only once we hit 35 or so, and we start to hear of contemporaries suffering major illnesses or conditions, that it tends to dawn on us that actually we're not...



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*Source: TAL

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* Source: http://www.asic.gov.au/regulatory-resources/find-a-document/reports/rep-498-life-insurance-claims-an-industry-review/

Dialing in for pandemic care

Australians have quickly learned to appreciate the benefits of digitised medicine, but careful monitoring is needed to keep data secure.

COVID-19 has slowed many aspects of our society and economy but there are some things it has accelerated – particularly the uptake of technology. Yet experts warn that great opportunity comes with great challenges around misuse and cybersecurity as hackers are out in force.

In medicine, the pandemic has helped reduce the barriers to digital take-up that have undermined telehealth for a decade, particularly Medicare rebates for consultations by phone or video.

After years of debate, a total of 274 new MBS items had been created and implemented in six weeks of COVID restrictions in Australia, with the first items commencing on 13 March 2020.

By October 2020, a CommBank GP Insights Report with HealthCert found more than 95 per cent of Australian general practices were offering telehealth in response to the pandemic, up from just 19 per cent the same time last year.

The Centre for Online Health (Figure 1) shows 166.6 million Medicare Benefit Schedule (MBS) telehealth consultations from March to September 2020, with 16.7 million in September alone. More than 90 per cent of these were telephone consults with less than 10 per cent videoconferencing – even in specialties such as ophthalmology. During this period more than 30 per cent of general practitioner consultations were via telehealth.

The technology take-up was driven by millennials (born between 1981 and 1994/5) and Gen Z (1995-2012/15), who are comfortable with interacting online. Across the country, 73 per cent of Australians said they had either accessed telehealth or were open to virtual consultations. Before the pandemic, just 3 per cent of patients had participated in a telehealth consultation.

While advocating for telehealth, the AMA and other organisations have warned that the increasing trend towards digitalisation must be accompanied by greater cyber security and protocols.

Medical practices, private hospitals and pharmacies, like other smaller businesses, are particularly vulnerable to cyberattacks as they often have under-resourced cyber-security. The federal government recently advised that organised criminal networks are using the COVID-19 outbreak to intensify hacking efforts with phishing emails and SMS messages embedded with malicious links.[1]

Health systems were already a target of cyber-criminals before the pandemic. The Royal Australian College of General Practitioners (RACGP) – Expert Committee Practice Technology and Management reported Australia's health sector accounted for 22 per cent of all data breaches between July and December 2019, making it the highest reporting sector in Australia.

Yet only a third of Australian healthcare organisations embed cyber-security awareness and training into their policies and procedures.[2]

In June 2020, the Australian Digital Health Agency (ADHA) partnered with cyber-security firm Cyber CX to produce guidelines to help health organisations use telehealth and conferencing securely. The agency advises medical practices to use the latest operating system version and install updates as soon as they are available to close the security gaps that enable cybercriminals to infiltrate their systems.

ADHA has prepared a toolkit to help healthcare practices meet their data security, privacy and other legislative and professional requirements.

The 'Using Online Conferencing Technologies Securely - A guide for healthcare organisations 'Connected, secure consultations' provides advice on important issues including the need for secure configuration, well-implemented encryption, access control and multi-factor authentication (MFA) when conferencing online.

The AMA has welcomed the Australian Government's decision to extend temporary Medicare Benefit Schedule (MBS) telehealth from March 2020 until March 2021 to help reduce the risk of community transmission of COVID-19

but warned appropriate regulation is needed to prevent misuse.

Counselling service Beyond Blue said telehealth has been particularly vital for those with mental health issues, providing continuity of care during COVID-19 restrictions.

Beyond Blue says telehealth should be an addition to the treatment toolkit which may provide a sense of security for some patients, encouraging them to speak more openly. [3]

Electronic prescriptions have also been fast-tracked during the COVID-19 pandemic after a protracted regulatory process to assist in containing the virus and to reduce medication-related problems. Under the new system, medications dispensed by pharmacists are collated in an electronic patient record to coordinate medications.

Meanwhile, in medicine as elsewhere, teleconferencing has replaced many scheduled conferences and meetings during the pandemic.

In a journal article on telehealth for global emergencies, the authors note that while telehealth has been particularly useful in providing continuity of care safely during COVID-19, its longer, sustainable use depends on developing a strategy for its integration into mainstream care. This will involve redesigning clinical models of care and adequate education and training for health professionals.[4]

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[1] *A. Galloway, Coronavirus cyberattackers going after hospitals, SMH, May 20, 2020, https://www.smh.com.au/politics/federal/coronavirus-cyber-attackers-going-after-hospitals-20200520-p54uq3.html*

[2] *A. Tsirtsakis, Health sector remains biggest reporter of data breaches, 20 August, 2020, newsGP, https://www1.racgp.org.au/newsgp/professional/health-sector-remains-biggest-reporter-of-data-brea*

[3] *Beyond Blue, Managing my daily life, https://coronavirus.beyondblue.org.au/managing-my-daily-life/coping-with-isolation-and-being-at-home/telehealth-a-useful-way-to-access-support.html*

[4] *A. Smith, E. Thomas, C. Snoswell, H Haydon, A Mehrotra, J. Clemenson, L Caffery, Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19), vol 26/5, 2020, p 309-313, https://journals.sagepub.com/doi/pdf/10.1177/1357633X20916567.*

Living, dying and grieving well

The pandemic and its restrictions have prompted many questions about lingering grief and bereavement, write Palliative Care SA's Professor Gregory Crawford and Mark Waters.

Palliative Care SA Chair Professor Gregory Crawford (left) and Executive Director Mark Waters

'Grief and bereavement' is the fifth stage of palliative care. As a result of COVID-19, many people have been discussing what happens with people's grief in the long term. If people were to die in isolation without family connectedness and touch, might that lead to unresolved grief? If families have been separated due to border closures, how will this affect people's future sense of loss? If funerals have been held where limited numbers of people have been able to attend, what does this do to residual bereavement?

Palliative Care SA (PCSA) – whose mission is that all South Australians can live, die and grieve well – is part of a small project funded to explore these issues until June 2021. The advent of the COVID-19 pandemic has forced many people to consider their own mortality, risks taken and potential consequences. This applies to health and aged care workers and the general community alike.

PCSA's role in the project will be to develop community conversations about grief literacy using a 'compassionate communities' model. The group will also engage with general practitioners (GPs) about the grief issues they see in their practices and what options are available for their patients. We know 90 per cent of people who experience grief will be able to cope with their loss over time. But we are interested in the remaining 10 per cent who experience chronic and debilitating grief and what services are available for them.

At an organisational level, PCSA has seen significant coordination at national and state level since during 2020. Palliative Care Australia (PCA) quickly convened the Australian COVID-19 Palliative Care Working Group. All state and territory palliative care associations have been meeting regularly to share information through our networks. Clinicians from South Australia were part of national conversations as they contributed to sub-groups and working parties.

Initial fears emerged of people dying in isolation without family members as had been witnessed overseas. Or, if there was a family member present, they still would not be able to touch their loved ones. To a great extent, this did not occur in South Australia. However, anyone residing in or visiting aged care facilities understands the isolation and severe restrictions that continue to apply.

The revolution of telehealth has been a major gain from the past eight months. The Australian Government funding of consultations over the phone or via video link is transformative and should continue. The ability for palliative care workers to consult into people's homes where there are restrictions upon entry due to lockdown has been highly valued by patients, their carers and extended family. This system has strengthened the links from Specialist Palliative Care Services into country South Australia, improving access to palliative care assessment, advice and support during this time. While telehealth is not always the best form of contact and assessment, especially where complex needs apply, it has helped on a number of fronts. Advocacy is needed by organisations such as the AMA and PCSA to ensure positive developments relating to telehealth become embedded as core policy, funding and practice.

Restrictions have applied to Community Palliative Care teams visiting people in their homes. Volunteers, as part of a patient's social support, have been cancelled. Much telephone contact has occurred to check how patients are, but it is not the same as personal visits. Volunteers were starting to conduct community visits until the lockdown on 19 November 2020 forced a closure to that program once again; hopefully, it won't be as long to reinstate as previously occurred.

Decision-making has been brought to the fore during the pandemic. Choices to stay in place, either at home or in aged care settings have been accentuated. Advance Care Planning has been more evident with anticipatory conversations about goals of care being raised more frequently. For several months, it was apparent that people were electing not to go to hospital if at all possible, and GPs and Community Palliative Care teams were looking to support people to die at home. During the months of COVID-19 constraints, PCSA has provided more education about Advance Care Directives and the need for the clinical 7-Step Resuscitation Pathway. PCSA has been trying to ensure that people's wishes are well documented. It is even more critical that people have appointed their substitute decision-makers, so they are ready to act for the person and have wishes understood. There has also been a significant increase in interest from residential aged care facilities to have documents and decision-making in place.

COVID-19 has also led to more recognition of the need for self-care. Health and aged care professionals and workers need to be aware of their own needs for care, too. How are they looking after themselves? How are they looking after each other? How can carers be supported to have some time for themselves and re-charge their batteries to continue their vital role in the community? PCSA has been using 2020 to focus upon these concerns and has held webinars around these topics. After all, now more than ever before, we need to be kind to ourselves as well as each other.

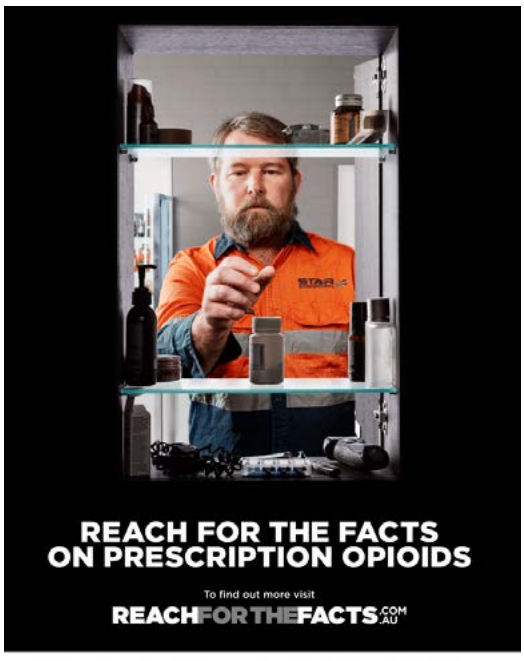
Professor Gregory Crawford is Chair and Mark Waters the Executive Director of Palliative Care SA.

Opioid campaign raising awareness

The AMA(SA) continues to support the ReachForTheFacts campaign led by ReturnToWorkSA, which asks doctors and the community to think about the potential side effects when prescribing or using opioids for chronic pain. RTWSA Medical Advisor Dr Chris Bollen explains why the campaign, now in its second year, continues to be so important.

At ReturnToWorkSA we continue to recognise the issues and negative impacts prescription opioids can have on our injured workers' recovery and return to work after injury, as well as their safety in the workplace. The impacts of prescription opioids are not unique to our work injury scheme, but remain part of a broader community challenge.

The ReachForTheFacts campaign, launched in July 2019, is a South Australian-based community campaign that raises awareness of the potential harms of long-term use or misuse of prescription opioids; encourages questions about alternatives for safe, effective pain management; and aims to trigger behavioural change. Phase One of the campaign encouraged the community to ask, 'What are you reaching for?' and 'Reach for the facts on prescription opioids'. This campaign asked the audience to reconsider their relationship with opioids.



Support for the campaign from local and national stakeholders who collaborate, inform and promote the campaign continues to grow. New supporters include the Royal Australasian College of Surgeons and the Therapeutics Good Administration.

The television advertisement had almost 4.5 million views and campaign assets for ReachForTheFacts appeared online 3.6 million times. Medical practices across Adelaide that displayed brochures reported a significant number being taken from the practice and the ReachForTheFacts website was visited almost 36,000 times.

Market research conducted in March and April of this year provided some useful insights and validation for the campaign. One of its objectives was to raise awareness of the dangers of long-term use of prescription opioids. The research found higher levels of community awareness of all opioid-related side effects including physical dependence and addiction. In addition, awareness of medications such as opioids increased, and there was significantly less uncertainty about what people understood opioids to be.

Another Phase One objective was to increase the number of individuals who discuss with their health professionals options other than opioids for safe and effective pain management. Market research showed a 25 per cent increase in how comfortable people are talking to their health professionals about pain management, and an eight per cent increase in the comfort of doctors in talking to their patients about pain management.

Phase Two of the campaign explores the wider risks associated with opioid usage and aims to raise audience awareness of both the side-effects and the biopsychosocial-related issues such as absenteeism, impacts on relationships, fatigue, and effects on older persons.

The second phase will feature new television and cinema advertisements in 2021, given the market research suggested strong recall of the campaign through television. The television, cinema and radio advertisements; social media; billboards and posters; and brochures will continue to point consumers, family members and health professionals to www.reachforthefacts.com.au. There they can find tailored information about opioids and their side effects, tools to identify dependency, information about pain, and multi-modal methods of pain management. The testimonials remain a powerful feature and offer an honest and compelling insight into local South Australian's experiences with prescription opioids. It is important to stress that the information presented is objective and non-judgmental, and strongly encourages consumers to discuss any potential changes to their pain medication with their doctors.

With the campaign now in its second year, the website resources have increased substantially and continue to be refreshed as new material comes to hand for both consumers and health professionals. The health professional pages also provide up-to-date information about prescribing and deprescribing, as well as useful patient information about pain and the side effects of prescription opioids. I highly recommend medical practitioners use these excellent resources in their practice, to not only support the education of their patients but importantly to update themselves on all the issues of opioids, as the evidence for their usage has changed.

Any feedback about the campaign can be provided to campaign@rtwsa.com.

New technology, new hope

SAHMRI's New Proton Therapy Centre is a ray of light for cancer treatment in Australia.

The new Australian Bragg Centre for Proton Therapy and Research will not only be a game changer for cancer treatment in Australia, it will also establish Adelaide as one of Australia's leading cancer treatment centres.

That's the word from the team that has been lobbying for 20 years for a national proton beam therapy centre to treat cancers with highly targeted radiation.

Work is now well underway on the new centre at the South Australian Health and Medical Research Institute (SAHMRI) and efforts are intensifying to identify a pipeline of talent ahead of the planned opening.

'This is a generational, once-in-a-lifetime major event. Not only is it going to be well resourced, it will treat patients from interstate and overseas. This will be a centre of international excellence,' says Royal Adelaide Hospital (RAH) radiation oncologist Associate Professor Michael Penniment.

The treatment is expected to be particularly valuable for paediatric patients; they face significant ongoing side-effects from irradiating healthy tissue, including learning difficulties, hearing and sight loss, and endocrine dysfunction. It will also be used for adult patients with complex head, neck and spine tumours difficult to treat with traditional radiotherapy.

The ProTom International proton beam machine acquired by the Bragg Centre is similar to those installed in Boston's Massachusetts General Hospital and the McLaren Proton Therapy Centre in Flint, Michigan. Sharing technical expertise is expected to deepen the ties South Australia has with leading international proton therapy institutions.

Associate Professor Michael Penniment - radiation oncologist, Associate Professor Hien Le - radiation oncologist, Associate Professor Peter Gorayski - radiation oncologist, and Dr Scott Penfold – medical physicist at the site of the new Australian Bragg Centre on North Terrace.

While proton therapy units are being developed in Singapore, Taiwan and Indonesia, the Bragg Centre is expected to fill a large gap in Australia and the Asia-Pacific region.

'The Bragg Centre will sit in SAHMRI and will have a focus on equitable treatment – that will be the key,' Associate Professor Penniment says.

'It will focus on ensuring patients are treated according to their disease, not their ability to pay, while there will also be scope for fee-paying patients from overseas.

'There will be tremendous opportunities for every doctor in Adelaide who has an interest in cancer treatment. We would hope there would be public and private flow-ons.'

The cost of proton beam therapy machines has declined from around $300 million over the past decade but remains in the tens of millions and the large up-front capital costs limit the availability of this technology.

Currently only around 10-20 Australians are able to access treatment per annum – mainly in the US – with the Federal Government funding treatment costs that can be more than $150,000 for each patient.

It's expected that the new centre will initially treat around 200 patients, ramping up to around 600-700 patients a year.

'We expect to move from only treating a dozen or two paediatric cases with radiotherapy in Adelaide to a large majority of patients requiring radiotherapy across Australia being treated here in Adelaide,' Associate Professor Penniment says.

In the past five years, the RAH has developed a computer modelling service that analyses the utility of proton beam therapy for individual cases, helping to build a national assessment network. This system will

also be used to identify appropriate cases for proton therapy at the new centre.

'One of our radiation therapists came in the top five of planners internationally – pretty amazing given we don't even have a proton therapy unit in Australia yet. We've been building a team with international credibility,' Associate Professor Penniment says.

While most of the state's graduating radiation oncologists find positions interstate or overseas, the Bragg Centre will provide significant opportunities for South Australians, including graduates from basic sciences, pre-clinical, research and treatment. South Australia is already working to build workforce capability and a virtual queue is forming among clinicians to work in the new centre. Leading international paediatric radiation oncologists are also planning their sabbaticals to help the new facility get underway.

Associate Professor Penniment says the expectation is the centre will employ about 15 radiation therapists and 10 medical physicists. In terms of doctors, he predicts there will be some fractional appointments, with as many as four training positions and four consultants.

'We've got a few years to develop a workforce that goes all the way from engaging with the universities to train people for the existing courses – and that's largely radiation therapy medicine and physics – but also I think there is going to be a significant flow-on to clinicians who work in all aspects that touch on cancer treatment. We see that as tremendous opportunity,' Associate Professor Penniment says.

'We're not going to put a stress on the current health system. We're going to provide an opportunity for it to become one of the leading health sectors in the world.'

Medical physicist Dr Scott Penfold, who has been involved in the long quest to establish a proton therapy centre in Australia, has recently been appointed as the centre's first employee, undertaking radiation safety assessments and designing tests to verify the new machine's technical specifications.

He's also part of the Bragg Centre team applying for new Medicare item numbers for proton therapy in an attempt to ensure equitable access to this limited resource. The new Medicare items will initially focus on paediatric, and adolescent and young adult (AYA) cancer, and certain rare adult cancers.

'We believe many adult cancers can benefit from proton therapy, but the international clinical trials for many of these are ongoing. The results will likely play a role in the future use of proton therapy in Australia,' Dr Penfold says.

'From our cost-utility studies the value is definitely there for many paediatric and AYA patients and certain adult cases, despite the large capital costs.'

The centre is looking to build partnerships for key research projects, including innovative imaging solutions for adaptive proton therapy and establishing a national clinical network.

'We envisage a national referral network that will meet [virtually] to discuss the patients referred to the centre in Adelaide – that's an approach employed in several European healthcare systems where they just have access to only one or two proton therapy centres across the country,' Dr Penfold says. 'The multidisciplinary team come together to decide which patients will benefit from proton therapy.'

In his role as Chair of the Particle Therapy Working Group of the Australian College of Physical Scientists and Engineers in Medicine (ACPSEM), Dr Penfold is also involved in developing professional standards for medical physics working in proton therapy.

An end to restless nights

Help is on the way for GPs looking to help patients with insomnia.

Sleep is an essential biological requirement for mental wellbeing and physical health – but is not as simple as it seems.

That's why a Flinders University research team is working to provide general practitioners with information about evidence-based treatment for the sleep disorders that affect many of their patients.

The two most common sleep disorders, insomnia and obstructive sleep apnoea, collectively occur in more than four million Australians and are commonly managed by Australian general practitioners (GPs). Insomnia and sleep apnoea reduce quality of life, increase risk of medical and mental health conditions, and contribute to high healthcare utilisation costs.

Flinders University researcher Dr Alexander Sweetman says that while evidence-based treatments for both conditions exist, GPs commonly report limited access to information, treatment and referral options to manage sleep disorders.

Dr Sweetman is part of a multi-disciplinary team aiming to provide Australian GPs with tools and treatment options to manage sleep disorders. He works with sleep specialists, GPs, psychologists, researchers, health economists and translation experts to improve knowledge and access to evidence-based treatments for insomnia and sleep apnoea.

Researchers at the Adelaide Institute for Sleep Health at Flinders University, and the Discipline of General Practice at University of Adelaide, aim to provide Australian GPs with a suite of information, assessment, treatment, and referral options to manage sleep – and to reduce reliance on sedatives.

The research has recently demonstrated that non-drug treatment of insomnia improves sleep, and commonly also improves other associated symptoms such as depression, anxiety, and psychological distress (See article here).

'It's clear that insomnia is a common and debilitating disorder in Australian general practice patients, which requires targeted diagnostic and treatment attention,' Dr Sweetman says.

Chronic insomnia is characterised by self-reported difficulties falling asleep or maintaining sleep throughout the night, and impaired feelings or functioning during the day which persist for at least three months. Chronic insomnia occurs in 10 per cent of Australian adults, with GPs commonly managing their insomnia symptoms.

When insomnia occurs with other medical and psychiatric conditions such as chronic pain or depression, the insomnia should be considered as a 'co-morbid' condition that is responsive to targeted insomnia treatment, Dr Sweetman says.

He says research has found that the most effective treatment for insomnia is cognitive behavioural therapy for insomnia (CBTi) – recommended as first-line treatment for insomnia by the RACGP and many sleep, medical and primary care associations world-wide.

CBTi includes educational, cognitive, and behavioural components that directly target the underlying causes of insomnia. Dr Sweetman says CBTi leads to better sleep, daytime functioning and quality of life, with improvements persisting when treatment stops.

Yet, he says, while clinical guidelines strongly recommend CBTi as first-line treatment, most patients with insomnia are prescribed sedative-hypnotic medicines such as benzodiazepines or 'z-drugs' as the first-line approach, with many patients remaining on these medicines for many months or years.

'We are committed to providing general practitioners with more information, tools, and treatment options for insomnia according to guideline recommendations. This may allow them to manage more patients with CBTi and reduce reliance on sedative-hypnotic prescriptions as the "default" approach to manage insomnia,' Dr Sweetman says.

'We have recently published several articles to provide a step-by-step guide to administering CBTi during general practice consultations and to provide information about different evidence-based CBTi treatment options for insomnia. We've found that CBTi also improves symptoms of depression, anxiety and stress and have reported in a large review of more than 10,000 patients that CBTi is associated with improved sleep and reduced dependence on sedative-hypnotic medicine use.'

Flinders University researcher Dr Alexander Sweetman

While CBTi has historically been administered by trained therapists, it has recently been translated to online self-guided programs, ideal for the time limits of GP appointments.

Dr Sweetman's group has developed and tested a four-session CBTi program, effective in a range of co-morbid conditions, which can be administered by GPs and nurses, and hopes to roll this out to Australian general practices.

One of these, Sleepio, includes six-weekly online sessions with an animated character ('The Prof'), who guides patients to self-administer effective cognitive and behavioural treatment strategies. It has previously been shown to improve sleep, daytime functioning and mental health, and reduce dependence on sedatives.

'We would love to hear from GPs in South Australia who would like to have improved support and management options for insomnia and sleep apnoea,' Dr Sweetman says.

'We've developed a software-assisted pathway to help GPs to identify patients with insomnia, and to use the CBTi program Sleepio to treat their insomnia, reducing dependence on sedative-hypnotic medicine. This pathway is based on RACGP clinical insomnia management guidelines and evidence-based diagnostic and treatment tools.'The pathway is available through the Doctors Control Panel software (https://www.doctorscontrolpanel.com.au/). To find out more contact Dr Alexander Sweetman at the Adelaide Institute for Sleep Health (alexander.sweetman@flinders.edu.au).

Mounting case for subtotal tonsil surgery

Professor of Otolaryngology at Flinders University, Simon Carney

Mounting clinical data points to the need to invest in subtotal tonsil surgery (tonsillotomy) — including learning the technique and allowing additional time to perform the procedure, says Professor of Otolaryngology at Flinders University, Simon Carney.

Professor Carney says clinical studies of large numbers of subtotal tonsil surgery patients in Australia and overseas have indicated that the procedure, which is appropriate for patients with enlarged tonsils, consistently results in less pain, bleeding and a quicker recovery.

Children with obstructed breathing during sleep often have their tonsils removed – usually via a total tonsillectomy which involves the removal of the entire tonsillar capsule. The main risks following total tonsillectomy include haemorrhage and a prolonged return to regular activity due to pain.

In recent years, subtotal tonsil surgery has become more common, particularly overseas. But it remains controversial, with some maintaining that a full tonsillectomy remains as the only tonsil procedure that should ever be performed for either infective or obstructive symptoms.

Recent publication of a study of Professor Carney's subtotal tonsil surgery bleeding and pain outcomes for 608 paediatric patients over 10 years found the procedure was associated with a significant reduction in the prevalence and severity of bleeding. It also led to a more rapid return to normal activities when compared to total tonsillectomy.[1]

The study found that the total rate of any form of haemorrhagic event was 8.3 per cent (n = 23) for full tonsillectomy and 1.8 per cent (n = 6) for subtotal tonsil reduction. The range for return to normal activities in the full tonsillectomy group was three to 21 days post-operation, with 11.1 days the mean. In the subtotal tonsil group, this ranged from one to 14 days, with 4.6 days the mean.

'There's a growing body of evidence that this procedure has better outcomes than a full tonsillectomy for patients with sleep disorders caused by enlarged tonsils and adenoids although full tonsillectomies are still the gold standard for those with recurrent tonsillitis,' Professor Carney says.

He says it is also ideal as treatment of tonsil stones in adults, although this was not included in the recent study.

'Recurrent tonsillitis is much less common than in the past. By far the most common reason for tonsil surgery is now obstruction, most commonly causing snoring and sleep issues, as well as speech and eating problems in some cases,' Professor Carney says.

The study notes that tonsillectomy is one of the most common ear, nose and throat (ENT) procedures, with more than 35,000 tonsillectomies performed each year in Australian patients aged 17 and under.

The total tonsillectomy involves removing the entire tonsillar capsule, exposing a small portion of pharyngeal muscle, small blood vessels and free nerve endings. The main risks include haemorrhage and a prolonged return to regular activity due to pain.

In contrast, the tonsillotomy procedure commonly uses coblation, microdebrider, diathermy, argon plasma or laser, and leaves a small crescent moon of tissue intact rather than removing the whole tonsil.

For children with sleep disorders due to enlarged tonsils and adenoids, massive meta analyses, Cochrane reviews and other systematic reviews with data from multiple countries and thousands of children have all validated the Australian cohort data.

The research shows subtotal tonsil surgery reduces the likelihood of a return to theatre to stem bleeding by eight times and there is three times less chance of any bleeding at all.

Patients tend to return to normal activities, including a normal diet, four to six days faster, which alleviates concern for parents.

However, despite the growing body of evidence, and its popularity overseas, Australian clinicians have been slow to adopt the procedure, Professor Carney says. In the UK the procedure is performed in more than 50 per cent of cases and in the US over 85 per cent of ENT surgeons perform the technique, he says. In Scandinavia, where the surgery was pioneered, its use is even more common.

'Yet in Adelaide it is probably used in only 10 to 20 per cent of cases,' he says. 'That's probably because it takes about 15 minutes longer to perform and that has implications for scheduling and cost structures.

'At the moment in Australia the demand, to the extent that there is any for this treatment, is being driven by parents who have read the research. But most remain unaware of it as it is not generally offered by surgeons.

'It takes longer than a full tonsillectomy, but our data have shown the benefits are just so great, we believe parents need to be aware of this option.'

[1] *S. Attard and AS Carney, 'Paediatric patient bleeding and pain outcomes following subtotal (tonsillotomy) and total tonsillectomy: a 10-year consecutive, single surgeon series,' Australian and New Zealand Journal of Surgery, ANZJSurg.com, Royal Australasian College of Surgeons, 26 August 2020*

Testing conditions

Education and training providers including AMA(SA) were faced with new challenges in how to reach and engage their students in 2020, writes AMA Skills Training Manager Michelle Cockshell.

Challenges and difficulties have affected all of us in 2020. This includes the Registered Training Organisation arm of AMA(SA). As a result of the pandemic and subsequent fire at AMA House, AMA Skills Training had to adapt our delivery modes and options for student engagement.

AMA Skills Training is fortunate that, as a team, we already provided flexible training with a range of delivery methods – including self-paced learning, either online or written, classroom workshops and mentoring sessions – for accredited training. Due to COVID-19, like most training providers in South Australia we were forced to cancel all face-to-face learning for some time. However, the systems we have in place allowed us to transition with minor adjustments. We scheduled more one-on-one time with individual students for training and mentoring sessions, instead of in groups as is the more usual format. This required additional time for each trainer and assessor, which limited the amount of support that could be provided to students in any one day.

Students have been unable to commence/complete their required work placement (ageing and disability areas) which has resulted in additional mentoring being required. We scheduled Zoom classroom workshops for Diploma of Practice Management students once a month from May to August.

The knowledge, skills and teamwork of staff, trainers and assessors created a seamless transition to ensure the training journey for all students continued to be successful. Feedback from students shows that the support given during this time helped them cope with their learning and the changing guidelines, knowing that AMA Skills Training was available to support them at any time.

AMA Skills Training provides non-accredited professional development workshops once a month relevant to industry requirements. We recommenced these sessions in September via webinar, which has proved successful. In 2021 we will alternate between webinars and face-to-face workshops, to include a wider range of participants and increased learning flexibility.

The systems we have in place will support diverse learning opportunities for both current and future students.

Accredited qualifications

Nationally Recognised Training

- **BSB31115 Certificate III in Business Administration (Medical)**
- **HLT47315 Certificate IV in Health Administration**
- **HLT57715 Diploma of Practice Management**
- **BSB30415 Certificate III in Business Administration**
- **BSB51918 Diploma of Leadership and Management**
- **CHC33015 Certificate III in Individual Support (Ageing, Disability and Home and Community Specialisations)**
- **CHC43415 Certificate IV in Leisure and Health**

Accredited units

Nationally Recognised Training

- **HLTAID001 Provide cardiopulmonary resuscitation**
- **HLTAID003 Provide first aid**
- **HLTINFCOV001 Comply with infection prevention and control policies and procedures**

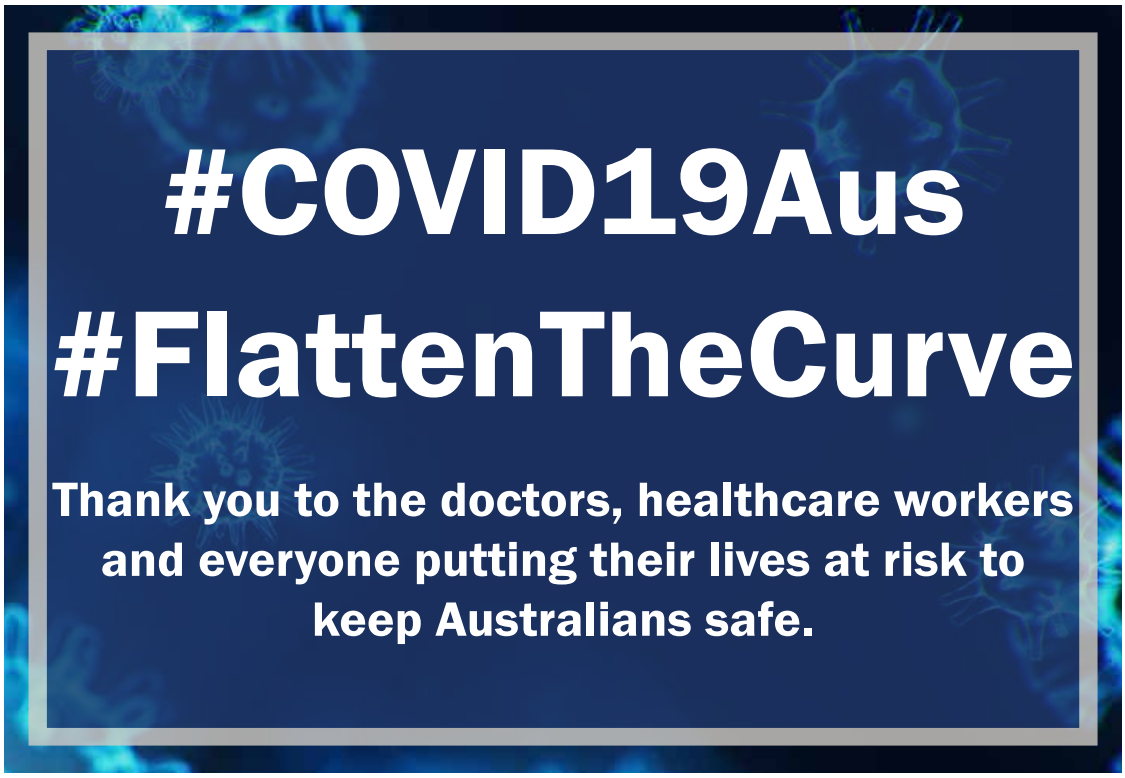
Non-accredited professional development

AMA Skills Training can tailor professional development workshops for your practice and staff. Popular topics include:

- **Providing Quality Customer Service**
- **Dealing with Difficult/Challenging Behaviour in a Healthcare Practice**
- **Key Aspects of Safe Instrument Reprocessing for You and Patient Safety**
- **Managing Challenging and Difficult Situations**
- **Leading a Winning Team**
- **Dealing with Workplace Bullying.**

General information is available on our website www.amaskillstraining.org.au.

Enquiries can be directed to phone 8361 0141 or email training@amaskillstraining.org.au.



Why your membership matters

Rebecca Hayward

AMA(SA) Member Services Manager

People choose to join, and stay with, a membership organisation for various reasons, be it belonging to their peak membership body, the availability of support services and informed advice, or accessing resources or commercial benefits. While all are important and valid, perhaps this year has reminded us that what matters most isn't determined by a dollar value, but what can be achieved when people unite to serve the greater good.

This year we've seen new barriers to delivering and receiving health care, and a demand on the medical profession to find solutions and adapt swiftly. Doctors and colleagues have had to overcome these barriers while continuing to deliver care to those who need it.

Throughout the pandemic and the challenges it has posed, the AMA has been front and centre in advocating for doctors and the community, and instrumental in delivering results. Whether you received or conducted a telehealth appointment, accessed PPE that kept you safe, used new COVID-19 resources developed for doctors in training, or shared information about COVID-19 that supported your patients' physical and mental health, you have directly benefited from AMA advocacy and the access to decision-makers around the country.

As we move into 2021, the respected, independent voice of the AMA remains more important than ever. However, as a not-for-profit membership organisation, and the only one representing all medical disciplines, the strength of our voice is reliant on the support of our members.

To our existing members, thank you. We could not have achieved all we have without you. Special thanks to those who have already renewed their membership for 2021.

If you are not a member, please consider joining us. By doing so you not only strengthen our voice, but also enhance our ability to strengthen yours and those of your colleagues and patients.

The gift of caring for others is a generous one. How important it is that doctors are safe in the knowledge you have the backing, support and representation that enables you to do so.

For further information about joining or renewing your membership, please contact membership@amasa.org.au or on 8361 0108.

Does your patient have a work injury?

Support for you

You can access free clinical support services, clinical tools and patient resources to support and facilitate your patient's effective treatment, recovery and return to work.

Support for your patient

ReturnToWorkSA has a range of services your patient may be able to access which can support them as they recover and return to work.

We're here to help

Visit our website to find out more rtwsa.com/service-providers.

Our goal is to make your life easier when it comes to navigating the Return to Work scheme.

For more information please call 8238 5757 or email providers@rtwsa.com.

Return to ***work***.
Return to ***life***.

Government of South Australia

Dr Jill Robinson
Councillor

AMA(SA) Council Meeting November 2020

The November meeting was held in our new temporary office at Greenhill Rd, due to the unfortunate fire at AMA House. This was a socially distanced 'tête-à-tête' meeting, which was welcomed by those able to participate in person after he restraints of Zoom, and as usual Dr Michelle Atchison demonstrated excellent 'chairpersonship'.

COVID-19 continued to be the focus of discussion. Council questioned the accuracy of temperature testing and how the accuracy compares to swab testing. The standards of PPE are still being addressed, in regard to recognised federal and state standards.

The much-debated cardiac paediatric services at the Women's and Children's Hospital have generated tension due to privacy issues and the AMA has provided support on behalf of the doctors at the hospital.

The Termination of Pregnancy Bill 2020 has focused on the decriminalisation of abortion and the AMA recognises this is an issue that not all members support.

The membership subscription for the 2021 year is to remain unchanged in view of COVID. The AMA Executive board chair, John Nelson, delivered a background briefing on current financials. There is to be a Constitutional Governance review to modernise and formalise the objectives of the AMA.

The collegial relationship with the Minister for Health and Wellbeing continues, and Council members were asked to put forward issues they would like included in the regular meetings between the Minister and AMA(SA) President Dr Chris Moy and Vice President Dr Atchison.

The issue of limited data access to improve clinical outcomes generated robust discussion, with Council suggesting there should be a merging of public and private sector data.

Doctors in Training representative Dr Hannah Szewczyk reported the launch of the 2020 Hospital Health Check survey. She noted that more than 1,400 candidates had been affected by the RACGP Registrar exam cancellation due to technical difficulties – an extremely unsatisfactory situtation. An internal and external review will be held and the exams have been rescheduled in the first week of December.

Dr Moy raised the issue of nuclear medicine and its by-products. Council noted that this is a controversial political issue, and that AMA commentary will only relate to the impacts of medical nuclear waste disposal.

Dr Simon Macklin
Councillor

AMA(SA) Council Meeting December 2020

The meeting of 3 December was the final Council gathering for 2020 in what has been a busy year for all of us. First, there were bushfires of the like never been seen before. Then was the rise of the SARS Cov 2 pandemic and we have watched as the virus has carved its way around the world. In South Australia, we have been lucky to have had strong leadership and active engagement of senior medical experts by our politicians. The AMA (SA), through our President Dr Chris Moy (now Federal AMA Vice-President) has been at the vanguard of the efforts to have a sensible and logical approach to minimise the health impacts of the pandemic in South Australia.

In the midst of this, a significant fire caused substantial structural damage at AMA House that necessitated our transfer to a new temporary home on the Fullarton Road, which we haven't been able to enjoy in quite the way we had hoped due to the requirement for social isolation!

In this last meeting for 2020, a wide range of issues was again discussed, ranging from the COVID-19 response to the proposed amendments to the Abortion Act, and the looming crisis in rural GP training to the progress of electronic prescribing. Rural GP hospital contract negotiations will continue in 2021; and the relocation of WCH will continue to be a work in progress to ensure a facility fit for purpose is put in place. AMA(SA) Council will continue to work in these spaces for the benefit of our patients and the staff who serve them.

To finish on a positive note, the AMA has been recognised in the top five ethical organisations in Australia and topped the table as the most ethical member organisation. High praise indeed. We have achieved the recognition that LHN Boards are responsible for bullying and harassment in the workplace, in addition to providing healthcare with fiscal responsibility.

Our medical student representatives Matilda Smale and Jack Rumbelow have moved onwards and upwards to start new lives as junior doctors. We thank them for the enthusiasm they have brought to Council, wish them well in their future endeavours, and look forward to welcoming them back to Council in the years to come.

It is time for recognition and nominations are now being sought for the two annual awards presented by the AMA: the AMA(SA) Award and the Medical Educator Award. Nominations are due by 25 February; forms can be obtained from Mrs Claudia Baccanello at claudia@amasa.org.au.

Class of 2020: six years in the making

JADE PISANIELLO
STUDENT NEWS:
ADELAIDE UNIVERSITY

As my time in medical school draws to a close, I am moved to reflect on the person I was before starting this journey. I still remember, in 2014, receiving that fateful email inviting me to sit an interview at the Adelaide Medical School. So, too, did the people who are now graduating alongside me as the Class of 2020. I remember the absolute thrill as well as the anxiety of it all – medical school was so close and yet so far in that moment. Six years down the line, and I wonder how the Class of 2020 would answer if interviewed again...

TELL US A BIT ABOUT YOURSELF

The Class of 2020 is a diverse and spirited group. They have experienced the evolution of the Adelaide medical program, and have grown in maturity and resilience through a program more challenging than that seen by most cohorts. Our hobbies include complaining about medical school and wearing RM Williams boots. Our weaknesses include participation in online discussion boards.

WHY DO YOU WANT TO BE A DOCTOR?

Six years down the line, and I think we would still mostly say the same thing: we want to help people. Our appreciation of what that means as health care professionals may have become more nuanced, but, nonetheless, it is passion that gives us the energy for the marathon that is medical school, and our cohort still has plentiful and obvious passion.

WHY ADELAIDE MEDICAL SCHOOL?

Although our reasons for choosing Adelaide in 2015 were diverse, I think now we would all have a common feeling about the qualities that would make us choose it again, if we were to go back. The camaraderie, the culture and the support have been phenomenal since day one. Adelaide Medical School has certainly been a balance of business and pleasure, but it has also been where we have made lifelong friends, learned amazing skills, and grown and developed as individuals.

I am the first to admit that six years ago, I never thought I would be where I am today. At that stage it seemed insurmountable. Before I got in, I thought that getting in was the challenge; it was later that I realised

that was just the beginning. We are once again at that stage now, where having reached a major hurdle we realise that it is but one step along the way. Previously we thought passing medical school was our greatest hurdle. With internship looming, it is becoming apparent that this is not the case. We are about to face a whole new set of challenges, but I can say with confidence that the Class of 2020 is more than up to the task.

In December I hand over my role to the incoming President, Patrick Kennewell. It has been an honour and a privilege to serve as President of the AMSS. I am confident Patrick, and other members of the incumbent executive and committee, will do an excellent job of serving the AMSS community. While this year has been far more challenging than I anticipated, I can reflect with pride on the way the entire Adelaide cohort has fared. I want to wish the fifth years the very best of luck with their final barrier assessments – I well remember being in your position, and I don't envy you. I am proud of the way you have all continued to thrive in a difficult year. Rest assured that your lives are not defined by your performance in these exams.

Above and below, AMSS students at Adelaide's three teaching hospitals in 2020.

To the younger years, I hope that 2021 sees a return to more normality. I am well aware of the effect that online learning and suspension of placement has had. It is an isolating experience, and I am once again proud of everyone who has persevered through it. I hope to see some of you on the wards next year!

Soon, applicants will interview for the Adelaide Medical School Class of 2026. I hope that those who commence medical school have the same experience as I did. Medical school has been the greatest adventure of my life (so far), shared with so many wonderful people. I have no doubt that the AMSS will continue to thrive, offering support and, of course, plenty of gaudium!

I want to thank everyone who has helped us get through six years of medical school. From the faculty to our friends and families, we could not have done it without you. Finally, I want to thank once more, everyone who has helped serve the AMSS throughout my time, but most especially through this tumultuous year. It has been a pleasure to have worked with you all.

Dr Jade Pisaniello will begin her internship with the Central Adelaide Local Health Network at the RAH on 13 January.

President no more - an unlikely commonality with Trump

LIAM RAMSEY
STUDENT NEWS:
FLINDERS UNIVERSITY

Writing my final piece for *medicSA* has brought a mixed set of emotions. For one, some personal relief that I have eased the editors' workload, as I regrettably did not study English in year 12. On another side of the coin it has prompted some reflective thoughts on my year as President of the Flinders Medical Student Society (FMSS), with Matilda Smale as the Senior Vice President (SVP), and our interactions with the student body and the College of Medicine and Public Health (CMPH) at Flinders University. It has been undeniably a successful year for FMSS in our continued advocacy work, adaptations of social and educational events and working towards creating a healthy culture among students. It has been a professional metamorphosis for me, transitioning from student to a leadership role and now going onto internship in 2021. I am very grateful for the opportunity to write on behalf of the FMSS throughout the year.

Advocacy really is the bread and (vegan) butter of being a student body President. It's our job to understand and represent diverse student populations in our medical schools. You cannot advocate for such a pluralistic group of individuals without getting to know them. For me, that was the most meaningful experience: getting to understand, actively listen to and develop relationships with all the students.

Liam Ramsey with FMSS Senior Vice President Matilda Smale at the Med Ball

The relationship with the College of Medicine and Public Health (CMPH) at Flinders University has functioned as a catalyst for a wide range of advocacy wins. These included the course continuing through COVID-19, pre-clinical students rapidly transitioning to an online curriculum, clinical students remaining on placement for the year, and re-invigoration of assessments. We feel a deep sense of privilege to have been invited into decision-making decisions around the future of the MD at Flinders. And we were so lucky to have Associate Professor Rosalie Grivell as the Director of Flinders' MD this year.

There has been meaningful change in the course, culture and student wellbeing. Student bodies are immense sources of knowledge and should be included – along with medical education experts, clinicians and community members – when designing medical schools. Students can help shape the degree to make us competent, empathetic and well-rounded doctors. The relationships formed between the school and FMSS is allowing this to happen.

As President, I wanted to 'change the culture at Flinders Medical School'. I possibly underestimated the complex intersectionality of factors that influence culture to think we could change it in a year. But I do believe we have made inroads in improving collegiality, challenging hyper-competitiveness, establishing additional support networks for students and re-emphasising the power of peer-peer mentoring. With the CMPH we have addressed many issues such as assessment ambiguity, assessment standard-setting, and clinical placement conditions that were also contributing to the frankly toxic culture that had developed in our student body. The CMPH was receptive to these concerns and throughout the year, under Rosalie's leadership, many of these issues have been addressed or are under review. There has been a palpable improvement in the culture and I hope it continues to be rebuilt and reinforced in coming years.

Socially distanced FMSS Executive committee members (top) Riya Ramakrishnan and Kvitika Mishira and (front) Liam Ramsey and Yuze Zhai

Being student President has accelerated many personal processes for me (hopefully not ageing). I had to grow up quickly to personally process and deal with both the large empathy burden I had taken on and how my relationships with peers would change. I had to communicate between many parties and understand how to repackage information into actionable content. It meant becoming an advocate for students and addressing my own biases. I had to maintain my sense of self and not be reduced to a mechanism of communication for student discontent. I have tried to maintain this sense of self. My role has redefined my professional image and provided me with deep gratitude and fulfilment. I developed new friendships and found new advocacy passions.

Thank you to Matilda and Rosalie for your support, mentorship and friendship. Thank you to *medicSA* for the support and the platform, and to readers for 'listening'.

Dr Liam Ramsey will intern at the RAH in 2021.

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AMA(SA) Doctors in Training Committee

It certainly has been a busy year for medical advocacy. Although it seems like a lifetime ago now, our year kicked off on 29 February with the AMA(SA) Culture and Bullying Summit, which hosted more than 50 key stakeholders.

As part of the Summit, the AMA(SA) Doctors in Training (DiT) Committee presented the findings from the '2019 South Australian Hospital Health Check Survey' that showed unacceptably high rates of bullying and harassment within our three main teaching hospitals, as well as high rates of fatigue among junior doctors and poor culture. The AMA-initiated changes state that Local Health Network Boards are responsible for promoting healthy workforce culture and the health, safety and wellbeing of staff. We hope recent work to include staff wellbeing as an LHN Board responsibility will improve workplace culture in medicine, something that will continue to be central to our advocacy.

Although delayed due to COVID-19, we ran our 2020 Hospital Health Check Survey in November and results will be available soon. We are interested to discover and report any change in the rates of bullying, fatigue and unpaid overtime, especially in the context of the pandemic, and considering the attention the issue has attracted in South Australia and across the country this year.

But COVID-19 has been the headliner of 2020 and it has had far-reaching impacts on doctors. One of the major effects on junior doctors has been the changes to training examinations; these have been cancelled, rescheduled, cancelled and rescheduled again, and changed to online formats. In more than one instance these electronic examinations have failed, exposing the lack of contingency planning by the colleges, which has caused great distress for many trainees already anxious about the exams and the impacts of the pandemic this year. The AMA Council of Doctors in Training (CDT) created and publicised a communique recommending minimum requirements for examination contingency plans and communication with candidates. AMACDT has been working with the colleges and the Australian Medical Council to have these recommendations implemented.

CDT has also been working on many other issues, including conditions for medical parents, and has recently had a new Position Statement on medical parents in training approved by Federal Council.

CDT has also produced position statements relating to general practice training and a recommended single employer model, rural training pathways, and the health and wellbeing of doctors and medical students. Members have been heavily involved in the proposed national changes to the internship and PGY2 framework that is in development.

Special interest groups and advisory committees within CDT focus on prevocational, vocational, general practice and industrial issues as well as wellbeing and policy development. These subgroups have helped expand engagement with the AMA, capitalised on the skill sets of our members and enabled the CDT to function more effectively.

It's been a year full of challenges, but with these challenges we have seen opportunity and more motivation for change. I am optimistic we can continue this momentum into 2021 and improve workplaces, culture and training for doctors in training across Australia.

Dr Hannah Szewczyk
Chair, AMA(SA)
Doctors in Training Committee

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ADELAIDE

AMA(SA) Committee of General Practice

It is 18 months since the AMA(SA) Committee of General Practice was re-convened, with me as chair and Penny Need as vice-chair. The initial group of 11 has recently increased with two new members, including one GP representing Doctors in Training.

We are ably supported by Catherine Waite of the AMA(SA) Secretariat, who took on the role after the departure of Heather Allanson.

Time has been spent establishing terms of reference and protocols, and understanding committee members' political, academic and clinical interests. Along with everyone else, we have adapted to Zoom meetings. Our rural and remote members appreciate the format as we are all, finally, attending and participating with the same constraints.

The roles of the committee are to:

- review AMA policies from a GP perspective
- advise the AMA as to our view of those policies
- review potential legislative changes, AMA standards and requests from the broader health community
- participate in forums relevant to our craft group.

As you can see, we have a wide-ranging brief.

Recent areas of discussion and review include COVID protocols, provision of telehealth, GP training, issues concerning the rural and remote workforce, RACGP advocacy, 'Hospital in the Home', driving medicals, and flu vaccine availability and distribution.

As an AMA Council of General Practice (AMACGP) Federal representative, I am also able to advocate South Australian GPs' views on policy and direction during the regular Federal meetings held throughout the year. The current focuses of our attention are the Australian Government's 10-year primary plan, for which the AMA has provided significant recommendations and the Aged Care Royal Commission report.

At our last AMA(SA) CGP meeting, held online on 4 November 2020, Dr Roger Sexton spoke to us about APHRA's changing approach in dealing with complaints against medical practitioners, and in particular how complaints are assessed to allow vexatious complaints to be resolved more rapidly. As a committee we are aware of the support our GP colleagues may need if they are ever the subjects of complaints, as well as in a wide range of clinical or administrative areas.

The AMA(SA) CGP will be contacting all GPs in the state in 2021 to outline the particular areas of interest of each current committee member, including our other committee memberships. We hope that by getting to know us a little better, you will have direct points of contact should you need to speak to colleagues about any problem or query.

I welcome any GP who wishes to join the AMA(SA) CGP to contact me via the Secretariat. You will need to be an AMA member; if you are not yet a member, please consider joining AMA(SA) to add your voice and contribute to the AMA's valuable advocacy here and around the country.

Dr Bridget Sawyer
Chair, AMA(SA)
Committee Of General Practice

AMA(SA) Road Safety Committee

As a consequence of COVID-19 and the AMA(SA) fire there have been few face-to-face meetings of the Road Safety Committee this year. Nevertheless, committee members have been active in pursuing the goal of 'ZERO for Road Crashes' in the future.

Activities have included:

- involvement of Committee members in South Australian Government road safety strategy planning
- a submission to State Opposition on road safety goals
- input into revision of fitness to drive guidelines.

The committee members continued to be very concerned about the high level of death and injury on our roads and continue to brainstorm how these can be reduced.

The AMA members of the committee are Dr Robert Atkinson, Dr Peter Ford, Dr Monika Moy, Dr Stephen Holmes, the President Dr. Chris Moy (ex officio), me, and Observer members Ms Mary-Lou Bishop and Mr Martin Small.

The points the committee have been emphasising include:

- government mandating of Collision Avoidance Technology in all new vehicles
- government support of public transport and cycling with separation of different transport modalities (e.g. separation of cycling paths from roads, separation of railways from roads)
- implementation of reduced speed limits in suburban streets, through shopping precincts and where children play (pointing out that when road works are done speed limits are lower than when completed even though the road workers have special signs and high visibility clothing; when road works are completed speed limits are increased despite the presence of pedestrians including children none of whom wear high visibility clothing)
- the importance of medical assessment of fitness to drive.

I thank the members of the committee, both AMA members and invited observers, and the AMASA for continued support of the committee.

Dr Bill Heddle
Chair, AMA(SA)
Road Safety Committee

Australian Society of Anaesthetists (SA & NT)

At the time of writing, South Australia is dealing with the first COVID-19 cluster for many months. I hope that by the time you read this we have not followed Victoria with our own 'second wave'. If we have, I imagine we will be well prepared due to the many lessons learned from our Victorian colleagues.

This has been a year full of lessons for the healthcare workforce as we have all become more vocal around the additional health and safety concerns faced in our workplaces. I am proud to represent an organisation that was particularly vocal in this field, with the Australian Society of Anaesthetists (ASA) being one of the key medical groups speaking up in the media and to governments for the wellbeing of our members.

The global pandemic put a new focus on anaesthetists at the frontline of critical care. The public certainly has a newfound appreciation of our role as intubation and ventilation became part of the general COVID vocabulary. An anaesthetist even featured on the cover of *Time* magazine as a frontline hero!

The ASA spoke up for the safety of anaesthetists and indeed for the healthcare workforce in general from the start of the pandemic in Australia. We were one of the first voices to call for a halt to elective surgery so we could adequately prepare, and we have continuously sought improvements in the recommendations for personal protection equipment (PPE) at national, state and hospital level.

The ASA established a COVID-19 Working Group in the first week of March and our first guidelines were published on our website on 13 March, only two days after the World Health Organization declared COVID-19 a pandemic. We have recently published our ninth edition of the guidelines and our website is a wealth of information, with resources on airway management, staff protection and pandemic planning. Wellbeing resources were also a key focus given the enormous impact that we know the pandemic has had on our frontline workers.

One of the major 'wins' for the ASA this year was successfully advocating for the inclusion of specialist anaesthetists in the COVID-19 MBS telehealth items for pre-hospital consultations. These temporary MBS items were originally due to expire at the end of September and have now been extended to the end of March next year. The ASA will be working to ensure the items become permanent.

Much of the ASA's advocacy work during 2020 has been around the call for mask fit-testing, especially as it became increasingly apparent that COVID posed a risk with aerosol transmission. Our interstate colleagues are envious of the respiratory protection program that has been in place in South Australia since 2013. We hope to see greater progress in this area of need in other states and territories for increased protection for our workforce.

Dr Brigid Brown

Chair, South Australia and Northern Territory Committee of Management Australian Society of Anaesthetists

Adelaide Medical Students' Foundation

The Adelaide Medical Students' Foundation (AMSF) is committed to serving and supporting Adelaide medical students at an individual, group, and organisational level. The Foundation works closely with organisations such as the Adelaide Medical Students' Society (AMSS) and the University of Adelaide to provide direct, tangible support to students.

Despite the impact of COVID-19 in 2020, the AMSF has continued to support medical students as best as possible in the circumstances. The largest impact of COVID-19 was limiting our travel scholarships and research conference grants; however, all other initiatives continued, including our Benevolent Fund and usual awards.

The foundation awarded the Kildea Prize to Daniel Subramanian, a third-year student with the highest clinical grades in the first two years of medical school. The Devitt Prize for surgical excellence was awarded to Thomas Bristow, for his performance in the fourth-year surgical MCQ examination. The foundation also awarded the Recognition Award to Teham Ahmad, for his exemplary efforts in educational advocacy that extended beyond the realm of his role as AMSS Vice-President (Education). The newly designed Ral Antic Rural Health Grant was also awarded to two students, to help them pursue rural education opportunities. Lastly, the annual Intern Teacher Awards and Student Teacher Awards are currently being awarded for 2020 to recognise the outstanding teaching efforts of interns and sixth-year medical students during this unprecedented time.

In 2021 the AMSF hopes to expand its relationships between both medical students and doctors, including through a mentoring program that is now being established. We look forward to welcoming first-year medical students into the profession, including by continuing the tradition of teaching them how to measure blood pressure and awarding introductory stethoscopes. We would love more doctors to guide the direction of our foundation in 2021. Finally, a large part of the AMSF is providing financial support for the University of Adelaide's medical students. For more information, and to donate, head to https://www.amsf.org.au

Victoria Langton

Chair, Graduate Advisory Committee, Adelaide Medical Students' Foundation (AMSF)

DREAMIN Foundation

Above and below, Professor Suren Krishnan and colleagues, including Dr Shridhar Krishnan, during recent visits to Mavanatha Health in Uganda.

DREAMIN is an acronym for the Dean Richards Endeavour to Assist the Medically Ill and Needy. It honours the memory of the late Dean Richards, a stalwart of the Rotary Club of Prospect and was founded in 2003 by our Founding patron Dr Jim Katsaros as the Adelaide Craniofacial Unit Foundation to help the international work of doctors at the Royal Adelaide Hospital.

Now renamed the DREAMIN Foundation, it is a charitable foundation grateful to receive tax-deductible donations from the public.

The foundation now provides a mechanism to support appropriate medical intervention services for those people in need in South Australia, Australia and developing countries. Currently chaired by me, our board comprises junior doctors and members of the Rotary Club of Prospect and the wider community.

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

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

International projects support hearing programs in Tonga. The Foundation was about to start a hearing program in Cambodia when the COVID crisis delayed the venture. However, we have continued to engage with our international contacts and in conjunction with the JBI (The Joanna Briggs Institute) are producing training and education for health care workers to deal with the COVID crisis in Africa.

We have been very fortunate to receive a generous bequest from a member of the Rotary Club of Prospect. This has allowed us, in conjunction with the Adelaide Medical Students Foundation, to create a scholarship in perpetuity to support junior doctors, training and providing service in developing nations.

The foundation has a strong interest in those within our community who are socioeconomically deprived. We have just partnered and provided funds to support the assessment and provision of support services to children with Autism Spectrum Disorders in the northern districts.

The DREAMIN Foundation organises fundraising events during the year to support the vital work being carried out by generous South Australians. As a charity, the DREAMIN Foundation is reliant on the generosity of members of the Prospect Rotary Club, associated medical professionals and members of the DREAMIN Foundation to raise much-needed funds. If you would like to donate, please visit our website www.dreamin.org.au or contact director the Board via the AMA(SA) Secretariat.

Professor Suren Krishnan
Chair, DREAMIN Foundation

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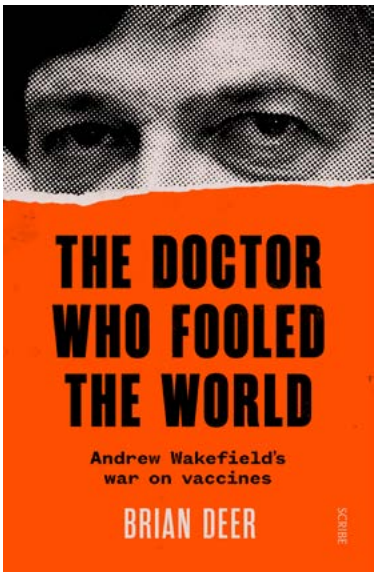
Injecting fear

A new book about the man largely responsible for misconceptions about the dangers of vaccinations has valuable lessons as the world waits for a COVID-19 vaccine, writes Dr Phil Harding.



The doctor who fooled the world
by Brian Deer

Scribe Publications, 2020

The doctor who fooled the world is well-respected English investigative journalist Brian Deer's account of the life and career of Andrew Wakefield. Wakefield, now aged 63, is – or was – a consultant physician and clinical researcher in the British National Health Service. Now, having been deregistered in 2010 and widely shunned by the research community, he is described in online biographies as an anti-vaccination activist and 'the darling of the anti-vaccination movement'.

Deer is a veteran British investigative journalist, best known for his inquiries into the drug industry, medicine, and social issues for the *Sunday Times of London*. Among his awards, Deer was twice named the UK's specialist reporter of the year, and in 2016 he was made Doctor of Letters (honoris causa) by York St. John University. His book could well have been titled 'The doctor who tried to fool the world' or even 'thought he had'. What precipitated his extraordinary fall from grace was Wakefield's development early in his career of an interest in inflammatory bowel disease, particularly Crohn's disease, and the notion that it might have a viral aetiology. Measles virus became a particular focus, with particles being described in tissue samples examined by some of Wakefield's research associates; this led to the idea that these might have originated from the measles vaccine, either the single virus variety or the measles mumps rubella (MMR) vaccine. The development of these notional associations might sound like the drawing of a long bow in a research sense, and probably was, but its basis in Wakefield's mind is described in great detail.

Wakefield was born into a medical family, his father a prominent neurologist and mother a general practitioner. He was brought up in the Bath area and attended a prestigious public school followed by undertaking medicine at St Mary's Hospital medical School in London, an institution well-known to many Adelaide graduates who have undertaken postgraduate training there – including yours truly – or anyone familiar with the NHS teaching hospital and research scene. The descriptions are so insightful of the medical politics and associated subtleties of these institutions that I would suggest the book as a 'must read' for anyone who has worked there.

Wakefield developed the hypothesis that there was a clinical association between Crohn's disease, vaccination, and what appeared to be a developing wave of autism and associated 'spectrum' behavioural disorders. The book provides fascinating detail about how this idea evolved in Wakefield's mind and how he went about recruiting subjects for research projects designed to prove the association, including manipulation of the media and the development of working relationships with lawyers interested in promoting class actions. Young children were subjected to invasive protocols to investigate their GI tracts. The work, later described by one observer as 'the scientific scam of the century' was mostly conducted at the Royal Free Hospital (which again will be very familiar to colleagues with London connections), and resulted in the publication by Wakefield and 12 of his colleagues of an article in the Lancet suggesting that MMR vaccine might predispose to behavioural regression and pervasive developmental disorder in children.

The publicity following the 1998 publication was shortly followed by a wave of anti-vaccination hysteria resulting in a major drop in vaccination rates and consequential outbreaks of measles, in particular, in a number of countries.

This article was much criticised and epidemiological studies published by others refuted the suggested link between vaccination and autism. The *Lancet* completely retracted the paper in February 2010 and, following the finding by the General Medical Council that there had been ethical violation and deliberate fraud – including failure to disclose financial interests – Wakefield's medical registration was cancelled.

Wakefield subsequently moved to the United States where he promoted the autism-vaccination concept and developed considerable notoriety in that country. In fact, in an eerie coincidence with current events, the opening passage in the book describes him publicly promoting his ideas at no less a function than Donald Trump's inauguration ball on 21 January 2017, a day I well remember having just arrived in Los Angeles from Australia for a conference and being somewhat concerned about the possibility of unrest associated with Trump's inauguration. Perhaps typically, Trump latched onto Wakefield's ideas, associated them with a perceived increase of spectrum disorders in his own family and said it was his idea that 'it's the shots'.

Overall, this book is a fascinating account of how medical practice and clinical research can very easily go badly wrong. It deserves to be widely read, particularly as very important work is going on towards development of a coronavirus vaccine.

‘What are you looking at?’

We can choose the way we see the world – and, in turn, how our view affects us – writes Dr Troye Wallett.

Dr Troye Wallett is a GP who likes to build things and to talk. He notices mountain bike riders, opportunities and fun. He is delighted about the idea that someone will notice Baader-Meinhoff after reading his writing and would love to hear from you. Email him at troye@troyewallett.com. and come for a ride

Two friends walk down a city street. The one turns to the other and says, ‘That’s a beautiful bird call – I don’t often hear it at this time of year.’ With astonishment, the second asks, ‘How can you hear a bird over all the traffic and noise of the city?’.

‘It’s all about what you listen for,’ says the first. ‘Watch…’

She takes a coin out of her pocket and drops it on the ground. The tin-on-cement sound is clear but soft. Around them, strangers turn and look for the obviously dropped coin. The woman smiles, picks up the coin and returns it to her pocket.

There is a kids’ game that is both endearing and annoying, depending on the prevailing mood. It is called *Spotto* and entails looking for yellow cars and calling out ‘SPOTTO’ when one is spotted. It is amazing how many yellow cars are on the road, but only noticed when you are looking. When was the last time you saw one?

The phenomenon described in both these situations is the Frequency Illusion. Every second our brain decides which stimuli to pay attention to and which to ignore. When something becomes important to us, we notice it. There is also an element of confirmation bias involved. If we are thinking about buying a Tesla because they are becoming popular, we start to see them everywhere, which confirms the idea that they are becoming popular. The illusion also occurs with new ideas, thoughts or experiences.

The Baader-Meinhof Group was a far-left militant West German organisation active in the 1970s and responsible for bombings and assassinations that lead to the death of 34 people. It has absolutely nothing to do with the Frequency Illusion except that the name has, amusingly, become synonymous with it. In the 1990s a commentator dubbed the Frequency Illusion the ‘Baader-Meinhof Phenomenon’ because he was surprised and amazed when he randomly heard of the group twice in 24 hours.

The term 'Baader-Meinhof Phenomenon' is a far more amusing term than Frequency Illusion and is used in this article from this point. It shows us that just because things are serious does not mean we can’t have fun.

The Baader-Meinhoff Phenomenon is powerful and can be used to direct one's life. It reminds us that what is noticed and what is ignored makes a significant difference to how we experience the world. It is like an Escher illusion, in which you see either a young or an old woman in the same picture.

Choose to notice the generous and kind and the world fills with kindness and generosity. Read the news and see fear and dismay, and the world fills with fear and dismay.

Whether you see opportunity and abundance, or scarcity is the same: a choice.

The world flows around and with us like the morning traffic in our daily commute. We can choose to see the yellow cars and yell with exuberance 'SPOTTO!', or we can focus on all the red lights and the selfish, entitled people that we perceive as cutting us off.

Choose to see abundance, kindness, opportunity and compassion and you will find them – just as you are bound to see yellow cars and Teslas after reading this article.

And what are the chances that you are going to come across Baader-Meinhoff in the next 24 hours; slim perhaps, but you will notice it if you do...

... 'News is to the mind what sugar is to the body ...'
- Rolf Dobell

Smart work, Volvo

In keeping with the support of contemporary technology and a particular interest in electric vehicles, regular reviewer Dr Rob Menz has test-driven a new Volvo hybrid.

The Volvo XC 40 has a 'preconditioning' feature that makes it more comfortable in early mornings in some climates.

Volvo has committed to electric vehicles across its fleet by 2025 and the XC 40 is the first example to hit the showrooms.

The petrol XC 40 was released in Australia two years ago and has picked up a slew of Car of the Year awards, including in Australia. It comes with a couple of variations, designated T4 and T5. They each use a similar two-litre engine but have different levels of power. The T4 is front-wheel-drive, and the T5 is all-wheel-drive. The plug-in electric vehicle (PHEV) also has T4 and T5 designated variants; both are front-wheel-drive. These are powered by a 1.5-litre turbocharged three-cylinder engine, again with different levels of power. The test car was the more powerful T5 featuring 132 kW from the petrol engine and 60 kW from the 10.7 kWh electric engine.

Long gone are the days of boxy Volvos with emphasis mainly on safety. Contemporary Volvos have a very smart design, although some commented that the C pillar was quite thick. There are a few clues to differentiate the recharge from the non-electric XC40s, including a subtle 'recharge' label at the top of the C pillar, a recharge badge on the tailgate, and a charging port in front of the passenger's door. The test car's numberplate (40 PHEV) was a further clue. The car is equipped with a three-metre charge cable that plugs into a household socket and recharges the battery in four to five hours. This charge is good for up to about 45 km, which is sufficient for most daily commutes. Other charging options include a specific charging port that can be attached to garage or carport wall, or using one of the increasing number of public charging stations. Volvo estimates approximately $2.80 per charge but this would be less if using solar power.

The fully electronic dashboard has replaced the odometer with another dial that gives information about power usage. The dashboard gives information about how much power is being used or how much electricity is being regenerated when slowing down or breaking. There are also indicators explaining distance to refill for both the battery and the fuel tank.

Drivers can choose between 'pure' driving mode, which is battery-only power; hybrid mode, where the car decides whether to use electric or petrol power; or petrol only. The most efficient use of power is in pure mode. When in hybrid mode battery power is preferentially used other than when there is high demand, such as in rapid acceleration or low temperatures.

A full tank of 95 RON petrol is good for several hundred kilometres. Volvo claims overall fuel economy of 2.2 litres per 100 kilometres and this may be achievable when the car is used mainly for daily commuting with overnight charging every day. The dashboard suggested the overall fuel economy on the test car was five litres per hundred kilometres.

There is a large touchscreen in the centre of the dashboard that controls the ancillary functions of the car including navigation, entertainment, phone connection, temperature, and seat heating (the rear passenger seats are also heated). Swiping the screen reveals several driver-assist modules that can be switched off; these include blindspot activation, a cross-traffic alert, a lane-keeping aid, and collision avoidance assistance.

Another safety feature is called 'city safety'. This feature is activated when there is a high risk of a collision. Initially there is an acoustic and visual warning signal from the dashboard, and this is followed by applying the brakes if the driver has not braked or swerved. The system has been designed to detect other vehicles, cyclists, pedestrians or large animals.

There is also a mode called 'preconditioning' that allows the car to be kept warm on chilly mornings and can be activated by a pre-set timer or, in some parts of the world, through a mobile phone app. A photograph in the brochure of some snow-covered cars in a car park alongside the Volvo demonstrates the value of this in certain climates.

Another useful feature is that if you return to your Volvo laden with shopping or suitcases, the electric tailgate can be operated by moving your foot under the left rear bumper. Similarly impressive is the automatic parking, which works for both parallel parking and perpendicular parking – although this was reverse in only and is not universally legal.

Most of the functions mentioned above can also be activated by voice control. Learning the satnav system proved interesting with my initial attempt to find a street in Thebarton. The satnav did not recognise Thebarton as a suburb but did direct me to the same street name in Adelaide – which proved to be the correct destination in Thebarton. However, the satnav misunderstood a road for a driveway and then tried to direct me right through the middle of Westend brewery, which of course has locked gates. Subsequent use of the satnav proved much more successful.

Driving the XC 40 was a breeze. The very comfortable seats are multi-adjustable with some electric controls and there are three pre-set positions. Driving position is high, which provides very good visibility (apart from the thick C pillar mentioned above, which can restrict the driver's rear quarter view). When in reverse there is a very clear 'helicopter' view of the car on the central infoscreen.

When driving at night the lights turn with the steering wheel, enabling the

driver to see around a corner. As with all electric vehicles the silence is uncanny. Despite the small displacement of the engines, the XC 40 keeps up with the traffic very easily (claimed 0 to 100 km per hour of 7.3 seconds is certainly brisk enough). Handling is aided by the low centre of gravity, with the batteries located in what used to be a transmission tunnel. 245/45 tyres on 20-inch rims also help. And despite the low-profile tires, the ride was remarkably smooth.

Four short days of testing did allow a Saturday afternoon drive through some lovely Adelaide Hills back roads to reach the Bridgewater Mill for an excellent lunch, and a Sunday afternoon drive to Victor Harbor for a sunset dinner in addition to the usual commuting around the city.

The XC40 proved to be quiet and efficient, and very capable of handling twisted Hills roads. Rear-seat passengers particularly enjoyed the views of trees through the panoramic sunroof. The XC 40 is claimed to be a five-seater, but our impression was that it would be uncomfortable for more than four occupants during anything but a very short trip.

The XC40 is priced at about $71,000, although the test car was fully optioned with extras including a heated steering wheel, windscreen washer water, and the enhanced parking assist. The test car was provided by Solitaire Volvo at Parkside; please contact them to arrange your test drive.

The fully electric XC 40 should be released in 2021. Of interest to those seeking higher-performance Volvos, there is also a Polestar sedan and wagon available. Polestar is to Volvo what AMG is to Mercedes, and the latest Polestar variants also have hybrid power.

Dr Robert Menz is a GP and enthusiastic motorist who has never owned a Volvo, although his mother has owned two.

NOTICES

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

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

North Adelaide Family Practice is looking for an energetic VR doctor to join our group of enthusiastic and supportive part-time GPs. The position is for a minimum of 4 sessions per week but can be flexible. We offer high quality medicine with fully private billing. Our accredited practice has excellent nursing and administrative support. Applicants need to have unrestricted registration, and interest in women's health desirable. T: 82672177, or email enquiries to maria@gpnafp.com.au

Dr Linda Ferris wishes to announce that as she will be turning 65 in March, she will cease private inpatient work but will continue to offer non-surgical consultations and second opinions for complex foot and ankle problems and continue caring for her own patients.

She will continue to be Head of the Orthopaedic Department at The Queen Elizabeth Hospital and continue with surgical and non-surgical foot and ankle services in public health care.

Dr Ferris has strong ongoing relationships with other foot and ankle surgeons and will forward patients for surgery if appropriate and will be happy to assist if required.

For enquiries and appointments – T: 8334 5900 F: 8267 2776 E: info@specialistcentral.com.au

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‘Courageous and principled’

Dr Ian Douglas Steven
MB BS (Adelaide), MD, MPH, FRACGP, FAFPHM

1945 – 2020

Dr Ian Steven (courtesy RACGP)

Ian Steven was educated at St Peters College and the University of Adelaide: he resided at St Mark's College, graduating MB BS in 1970, having won the St Mark's Collegians Prize as outstanding undergraduate in 1969.

His devotion to life-long learning is reflected in his further studies, resulting in his MD, FRACGP, MPH and FAFPHM. His studies, and his text book *Patient Presentations in General Practice, a Comprehensive Guide to Diagnosis and Management*, were reflective of his interests and were directed to informing himself to enable him to practice with ease across a variety of roles and of disciplines.

After graduation Ian travelled, first within Australia and then to England. His adventures included driving a second-hand Land Rover to Ethiopia via the Sahara Desert. He worked as a doctor, volunteering in a famine relief project.

His interest in Africa was long-standing and he travelled widely, interested in its history and culture.

He later donated a significant collection of artefacts to the South Australian Museum.

After returning to Adelaide Ian practised in Evandale, then set up his own practice in Collinswood (1978-1996). It was in this period that he gained his MD and MPH.

In the late 1980s Ian, as director of the RACGP research secretariat, brought together the independent networks of sentinel practices of the state-based research committees. He expanded the project, leading to the formation of ASPREN, the Australian Sentinel Practice Network, in 1990.

As an aside from practice Ian was the winner of the quiz show *Sale of the Century* in 1985.

Ian's professional life was rich and varied. Apart from his RACGP positions, he worked in a consulting role for Workcover SA, the WHO, the NHMRC Drug and Alcohol Services, and the SA Health Commission.

He saw the need for scrupulous management of pain, particularly relating to work injury and his specialist practice in this commenced in 1990.

Ian's interests included gemology and ornithology, which he shared with his wife Marg. They travelled extensively.

Ian is survived by Marg, his aunt, cousins and families.

On a personal note I met Ian in the John Martins department store in the early 1960s while buying our undergraduate academic gowns. He was a year behind me. We formed a comfortable if not close friendship. We had a shared interest in fishing, and also in the quality of medical care.

While Ian was Visiting Medical Consultant for WorkCover SA, I was President of the AMA in South Australia. Ian obtained permission to discuss with me a disturbing pattern of pethidine administration by a small number of doctors working for a deputising service which was billed to WorkCover. Some of the patients had been opioid naive and were not drug seekers. I was able to obtain information from the Health Issues Centre that showed a similar pattern. The statistics were damning. The AMA met with the relevant authorities, and prosecutions and suspensions resulted. Ian and I were both aware that the damage done to many of the victims was not reflected in the leniency of the penalties, and our attempts to discover why were thwarted.

However, as a result of recognition of the growing problem of opioid abuse, the Medical Board eventually approved an AMA(SA) Committee into Pain Management report. Pethidine, then commonly used for migraine headaches, was removed from the drug supply, eliminating it as a threat of iatrogenic addiction. All this resulted from Ian's courageous and principled stand, despite threats to his personal wellbeing.

Ian managed to balance his academic, social, recreational and personal life in an exemplary fashion and was critical of my inability to emulate him. Had I done so I would have spent more time with him.

Vale Ian.

Dr Peter Joseph

Expect the unexpected

Dr Brenton Graham Mollison
RFD, ED, ADC, MBBS, FRACOG, FRCOG

1936 – 2020

Dr Brenton Mollison

It is a testimony to his talent, drive and loyalty that Dr Brenton Mollison had two stellar careers in parallel – one as an eminent obstetrician and gynaecologist and the other as a commanding officer in the Australian army.

He was a man of enduring relationships – with his wife Pam; children Morag, Briony, Sandy and Tom; and grandchildren – and with great friendships that lasted a lifetime, including with students and in the military.

Brenton Mollison was born on 23 December 1936 as the only child of Tom and Dorrie Mollison, and lived in what is now Glenelg East for most of his early years.

His longest standing friend, Dr Graham West, recounted that – having forged a friendship when enrolling in the Infant School at Glenelg – they spent their youth spent playing cricket, football, tennis, swimming and mucking about in a canoe that Graham's dad built.

They continued to be great mates throughout their secondary schooling at St Peter's College, where Brenton was a prefect, and at the University of Adelaide Medical School where Brenton had won a Commonwealth scholarship.

They worked together in the dissecting room to learn anatomy, in the pathology museum to learn about diseases, and in the casualty department of the Royal Adelaide Hospital to gain practical experience in suturing wounds.

Brenton successfully completed his medical degree in 1960. The friends were parted for the first time in 1961 (after having spent 18 years together as students) when the young Dr Mollison worked as an intern at the Queen Elizabeth Hospital at Woodville while Dr West interned at the Royal Adelaide Hospital.

He met his wife, Pam, then a nurse at the Queen Elizabeth Hospital, and married in August 1963 before training in obstetrics and gynaecology at the Queen Victoria Maternity Hospital.

Dr Mollison obtained his membership of the Royal College of Obstetricians and Gynaecologists in the United Kingdom and returned in 1965 to private practice and at the Queen Victoria Maternity Hospital and the Women's and Children's Hospital. He also worked in Jamestown and Victor Harbor, earning the respect of the rural communities.

He served on the medical staff committee of the Queen Victoria Hospital from 1971 to 1994 and was Chair during a difficult period as the Queen Victoria Hospital merged with the Adelaide Children's Hospital.

He was known as a teacher with great drive, ingenuity and originality. His maxim 'expect the unexpected' was the north star guiding students in medicine and in the military throughout their careers.

Dr West recalled that his friend had three great loves – his family, the army and the Order of St John of Jerusalem. 'He aimed always to help those in need, developing methods to improve survival rates and patient care,' Dr West says.

'He was absolutely besotted with everything about the Army. He loved the history, the pageantry, the guns, the carefully documented routines and the special camaraderie he experienced in the Army.'

It was while at St Peter's College that the schoolboy Brenton began as a cadet officer. Colleague Dr Peter Byrne remembers him as a talented cadet underofficer and an excellent rifle shot.

Initially commissioned as an artillery officer, Dr Mollison transferred to the Royal Australian Army Medical Corps (RAAMC) in 1961. The pair served in the RAAMC and they both served in the Royal Army Military Corps (RAMC) in the UK, although 10 years apart, in 219 General Hospital.

On returning from the UK, Brenton commanded the 3rd Field Ambulance and the 3rd General Hospital with an infectious enthusiasm, Dr Byrne says. 'He gained an outstanding reputation as a commanding officer and an excellent trainer of medical officers and soldiers. His infectious enthusiasm was obvious in the innovative ways in which he imparted military medical knowledge.'

Dr Mollison was instrumental in the success of the expansion of the RAAMC in South Australia in the 1980s and 1990s, and is remembered as a source of advice and common sense. He was highly regarded by those with whom he served, Dr Byrne says.

During his career, he contributed to the Australian Medical Association, the South Australian Post Graduate Medical Association, the South Australian Salaried Medical Officers Association, the Royal Australian Artillery Association, the Royal United Services Institute of South Australia Inc, the Naval and Military and Air Force Club, and the United Farmers and Stockowners Association.

As well as being a longstanding office bearer of the Queen Victoria Medical Staff Society, Dr Mollison served on the Royal Australian College of Obstetricians and Gynaecologists (SA Branch), the South Australian Health Commission Mortality Committee, and on the board of the Adelaide Medical Centre for Women and Children.

Remarkably, he found time to devote to cattle farming (cutting a dash in moleskins and Akubra hat) and restoring old military vehicles.

He retired from obstetrics and gynaecology in 2001 due to mounting health issues but continued to lead an active life until the last few months.

Dr Mollison is remembered as a person who touched the lives of many people who 'enjoyed his cheery face, clever wit and benefited from his knowledge and kindness'.

With thanks to Drs Graham West, Peter Byrne and Rob Atkinson

AMA(SA) OFFICE CLOSURE

The AMA(SA) temporary office at Dulwich will close at noon on Tuesday, 22 December 2020, and reopen on Monday, 11 January 2021.

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

Since COVID-19 restrictions began in late March 2020, staff have been alternating between working from home and from the temporary accommodation at Level 1, 175 Fullarton Road, Dulwich.

Our phone numbers and email addresses remain the same.

Our postal address remains PO Box 134, North Adelaide SA, 5006.

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

Phone: 8361 0100

AMA(SA) DOCTORS SURVEY

The pandemic has shone a spotlight on the AMA and its potential for influence through simple messages and strong advocacy. Whether you're a member or a non-member doctor, we're keen to know your thoughts about thow the AMA has performed nationally and locally in 2020.

For more information please see the article on page 6, or to complete the survey please click here for members, and here for non-member doctors.

GALA DINNER AND AMA(SA) ANNUAL AWARDS

COVID-19 prevented AMA(SA) staging its annual Gala Dinner in 2020 and the presentation of annual awards.

We're aiming to stage a dinner next year, with the awards, on 22 May 2021. Details are being organised according to COVID-19 guidelines.

Nominations for the 2021 AMA(SA) Award for outstanding contribution to medicine by an AMA member, and the 2021 AMA(SA) Medical Educator Award, close on 25 February 2021. Nomination forms may be obtained by emailing Mrs Claudia Baccanello at claudia@amasa.org.au.

For more information about the dinner, please look for notices in The Voice e-newsletter and on our website, or see the February issue of *medicSA*.

FEBRUARY COUNCIL MEETING

The next meeting of the AMA(SA) Council will be held on Thursday, 4 February 2021.

Members may attend Council meetings. If you are a member and wish to attend the February meeting, please contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au, for up-to-date information about online or face-to-face formats necessary at that time.

DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

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

If you've been a student member but are no longer a student, please let us know so we can upgrade you to a 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.

DOWNLOADING YOUR TAX RECEIPT

Are you having trouble logging on to update your details, renew your tax-deductible membership for 2021, or print your tax invoice? Here's a simple tip to help:

- Head to: members.amasa.org.au
- Username: usually your email address
- Password: whatever you have set this as (there is a 'forgot password' option).

To access your tax invoice:

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

UPDATED FEES LIST OUT NOW

The latest AMA Fees List, released on 1 November, is now available. Existing members can access the list at no cost at https://feeslist.ama.com.au/. Non-members can buy an annual subscription for $499.

FREE MEMBER-ONLY SEMINAR

Managing and Growing your Personal Wealth

25 February 2021

6:15 pm for a 6:30 pm start

Hood Sweeney Boardroom, 11-16 South Terrace, Adelaide.

The event will also be live-streamed.

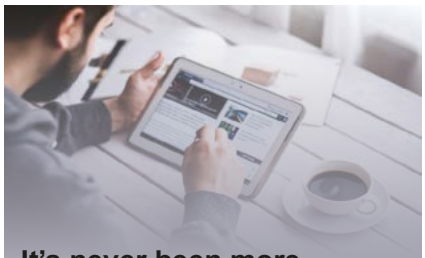
Learn the systematic, simple things you can do to help you reach your financial goals, regardless of your age or stage in life.

Topics include:

- Tax
- Running your personal finances like a business
- Making the most of your income
- Budgeting and how to use surplus income
- Protecting your greatest asset
- The latest on superannuation.

To register, go to https://sa.ama.com.au/events

For any enquiries please contact membership@amasa.org.au or 8361 0108.



It's never been more important to stay in touch.

For updates on AMA(SA) news and activities, please follow us:
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To ensure you receive future 'bumper' (June and December) editions of medicSA, please provide your name, phone, postal address and preferred email address to: medicSA@amasa.org.au.

If you are a member, check for our Informz newsletters in your inbox.

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❷ Insurance policies available through MIGA are underwritten by Medical Insurance Australia Pty Ltd (AFSL 255906). Membership services are provided by Medical Defence Association of South Australia Ltd. Before you make any decisions about any of our policies, please read our Product Disclosure Statement and Policy Wording and consider if it is appropriate for you. Call MIGA for a copy or visit our website at www.miga.com.au

Benson Radiology open at North Eastern Community Hospital

As the state's largest locally owned imaging Practice, Benson Radiology is delighted to announce the opening of its newest clinic

The opening of our clinic at the North Eastern Community Hospital in Campbelltown, allows us to bring our high quality imaging services to the referrers and patients of the inner north eastern suburbs.

Opening from January 2021, our new clinic will provide:

- CT
- X-ray
- Ultrasound
- Mammography
- Bone mineral densitometry
- Dental imaging

MRI will also be available from mid 2021.

Benson radiology

For more information visit
bensonradiology.com.au