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Fight of a lifetime

SA doctors on the frontline

AMA SOUTH AUSTRALIA

AMA(SA) CULTURE AND BULLYING SUMMIT WRAP-UP • CELEBRATING OUR NEW GRADUATES • SETTING UP WELLBEING SA • VALE SENIOR MEMBERS

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Contents

Toxic shock

COVID-19 has brought unique challenges to health systems around the world and presented unimaginable challenges to the doctors working within them. For this issue of *medicSA*, we asked AMA(SA) members who represent different medical specialties to write about how they are working to keep themselves, their patients and our communities safe and well. This special feature begins on page 9.

President's report

Dr Chris Moy

Responding to a novel threat

I think that most doctors will say they chose medicine as a career for the chance it offers to help people and to make a difference. Well, that was in the comfort of the good times. Now we face a pandemic event the likes of which none of us has seen. Amid our personal feelings of shock and panic, and the sudden threats to our own health and possibly financial foundations, we now have a chance to prove whether those noble impulses were for real.

Of course, we are helping people. We are performing, and preparing for, work that is literally changing the lives of patients who look to us at this time of need. And the AMA, here in South Australia and across the country, has been a cornerstone to the massive efforts to hold back and prepare for COVID-19, and to ensure that the health system continues to function.

It is a coincidence that the issue of *medicSA* in which we recognise the work so many of our doctors are doing to combat COVID-19 is one in which we celebrate the newest members of our profession in this state. The 2019 graduates of the University of Adelaide and Flinders University medical schools are named in these pages; each name represents years of sacrifice and toil, first to reach medical school and then to graduate. Even more than we are, I imagine they are wondering what they did in a previous life to deserve this – to confront COVID-19 as their first professional mountain.

It was only four months ago that I spoke to each class. So much has happened since then. Australia has borne the worst bushfires in our known history, with implications for our members, patients and communities for years to come. The AMA(SA) staged a very successful Culture and Bullying Summit, which illuminated the shameful levels of poor culture and bullying within many of this state's hospitals. I believe the Summit will lead to real change in what doctors can expect in health workplaces, which will be brought about by a genuine effort to 'design out' bullying and to embed a better culture in those workplaces.

And now this.

When I spoke at the graduation ceremonies, I pointed out that while we are convinced we will stay true to our ideals as we embark on our careers, it is much harder to hold on to them throughout our lives. I suggested that being a doctor can be incredibly rewarding, but that doctors may face professional and personal challenges that can guide them toward a different path. Bureaucracy, money, competition, a need for recognition, inevitable personal pressures – any or all can easily make us cynical, anxious and numb to the needs of the patients before us. Faced with any of these, we can lose the very point of what it is to be a doctor.

Right now, though, I am confident those graduates understand exactly the point.

It is difficult to believe how much the world has changed in a few short weeks. My first media statement about how we would work with SA Health to combat 'the novel coronavirus' was dated 28 January. In the weeks since, I have continued to urge everyone, within our profession and beyond, to look past individual need and to demonstrate the generosity so evident during and after the summer's bushfires.

Through this once-in-a-lifetime threat, we must, as a profession, pull together for the sake of the patients we serve and also show care for each other. In working collectively, and acting courageously individually, we can contribute to this war against our unseen enemy in the best way possible. Each of us now has a chance to honour the pledges we made at our graduations, and hopefully be able to remember this time as one in which others saw the best in us.

Editor's letter

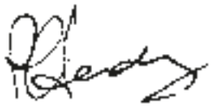
Dr Philip Harding

In the context of the current battle against COVID-19 and the difficulties being experienced by doctors and other health workers obtaining appropriate personal protective equipment, the accompanying substitute photograph of your editor sitting at his desk is intended as a historical and somewhat light-hearted reference to measures adopted by our colleagues during pandemics in times gone by. This mask, which I bought in Venice a few years ago, is an example of those used by Venetian 'plague doctors' at the times of the great plagues that swept Europe in the 17th century. Intended to protect against airborne disease, it was part of a costume also including gloves, an ankle-length overcoat and a leather hat. The beak could hold dried flowers such as roses and carnations, herbs including mints, spices, camphor, or a vinegar sponge. The purpose of the mask was to keep away bad smells, known as miasma, which were thought to be the principal cause of the disease before this idea was disproved by germ theory some two centuries later. It was believed at the time that the herbs would counter the evil smells of the plague and prevent doctors from becoming infected. Doctors also used wooden canes to point to parts of their patients' bodies needing attention and to examine patients without touching them. The canes were also used to keep people away and to remove clothing from plague victims without having to touch them.

I am unaware of any currently acceptable evidence that these measures of hygiene, personal protection and social distancing were effective in limiting transmission of Yersinia pestis, which is now thought to have been the infective agent of bubonic plague. It is to be hoped that measures similar in concept and now in place will be successful in preventing interpersonal transmission of COVID-19.

Recent media publicity showed one of our senior colleagues advocating a visit to the hardware store to obtain a suitable face mask. Perhaps going to a theatre shop or trawling through your travel paraphernalia might be an alternative, although once again I would not promote this as an evidence-based measure.

However you do it, please stay safe and keep well.



New social media guide outlines advice for practitioners

The AMA's new *Guide to Social Media and Medical Professionalism* says that while social media can provide professional benefits, inappropriate online behaviour can undermine professional integrity, relationships with patients and colleagues, public trust and future employment opportunities.

'The reality is that no matter what happens privately, you are always a doctor and need to consider how you present yourself. Your professional character may be judged by the way you conduct yourself online,' the guide says.

The guide provides case studies that demonstrate the damage that unwitting unprofessional behaviour on social media can cause. It suggests that before posting, you should always ask yourself: what would my patients/colleagues/employers say if they saw this? If in doubt, re-evaluate.

Also, control the pictures posted of you online. That pic of you doing cross fit in the operating theatre with a mate won't sit well with a current or prospective employer.

Patient confidentiality must also be protected at all costs, the guide warns – and that includes being careful with clinical images that also constitute medical information. Always obtain patient consent before posting or sharing an image and be aware that deleted images can remain on cached files on search engines.

If you do need to communicate with a colleague about a patient, check whether your employer has endorsed a platform rather than use social media channels such as What's App.

Maintaining appropriate boundaries between doctors and patients has always been complex in small communities but social media provides another layer of difficulty. Consider separating your public and professional social media channels, the guide suggests.

The guide says advertising on social media must follow established guidelines and policies, including the Medical Board of Australia's Code of Conduct. 'Medical professionals should be mindful of how accepting sponsorship on personal social media accounts and/or supporting products for financial gain may reflect on them as a doctor and/or influence them in their practice,' the guide says.

For more tips on social media and for a copy of the guide go to the AMA website.

AMA(SA) President Dr Chris Moy and Vice-President Dr Michelle Atchison with AMA President Dr Tony Bartone (second from left) and Vice-President Dr Chris Zappala (right) at the March AMA(SA) Council meeting

A campaign roadmap

National AMA leaders Dr Tony Bartone and Dr Chris Zappala have presented their draft vision for the Federal body.

The Federal AMA must be better at being 'proactive, visionary and forward-looking', AMA Vice-President Dr Chris Zappala says.

In presenting their vision for effective AMA advocacy at the AMA(SA) Council's March meeting, Dr Zappala and Federal President Dr Tony Bartone said the AMA must become 'a more progressive and thoughtful organisation'.

The presentation by Dr Bartone and Dr Zappala to the South Australian Council was one stop on a national tour before border lockdowns and national isolation measures were introduced.

Dr Bartone said a proposed new AMA strategic plan would change how the Federal body operates and interacts with the states and territories.

He said the new plan was based on the perceived need for targeted advocacy, efficient operations, renewed federation and accountability to members. A focus on 'big picture' Federal Government advocacy was prompting a review of other Federal AMA functions.

The AMA must 'develop a positive, aspirational view of what we want the healthcare system to look like in the future, underpinned by a few medium-term key campaigns'.

According to the draft strategy, the responsibility for member services and industrial representation would be passed further to state and territory AMA bodies, with the Federal body focusing on advocacy.

Fulfilment of the roadmap would achieve:

- Access to appropriate healthcare for all Australians
- Independence of the medical profession – including through assuring a medical-led system, reducing red tape and ensuring the future of private practice
- Sustainability of the medical workforce and healthcare system – including by acknowledging the diversity of the medical workforce and assuring doctor satisfaction with work conditions that are safe and free of bullying and discrimination, and by providing a clear vision of the future workforce, with clear training pathways and solutions to rural medical workforce needs
- Quality – by practising evidence-based medicine, introducing new technologies, committing to teaching and research, and promoting a profession-wide commitment to excellence and patient-centred care
- Patient autonomy – through ensuring choice across public and private systems and better choice of doctors, respecting patients' wishes about treatment decisions, and promoting public health and prevention.

Dr Bartone said he and Dr Zappala were keen to receive feedback on the draft strategy and ideas about the policy priorities for Federal campaigns.

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On the offence

AMA(SA) President Dr Chris Moy summarises the work of the AMA in South Australia and around the country that is increasing patient and member safety – and revolutionising our health system – in the face of COVID-19.

AMA(SA) President Dr Chris Moy at the Royal Adelaide Hospital, which has managed most of South Australia's COVID-19 patients

It's 11 years since I joined the Australian Medical Association's Council in South Australia, and six years since I first joined AMA Federal Council. But I can honestly say there has never been a similarly concise period in which we have done so much work with so much immediate impact for our members and our patients.

From our frequent, ongoing discussions with health and policy decision makers at the state and Federal levels, all the way to the Prime Minister, the AMA has been a vital, valued and respected contributor to determining what must happen and when to keep Australians safe in the midst of the COVID-19 pandemic.

Much of what has been achieved is obvious to members who have advocated for so long: developments in telehealth, for example. The breakthrough agreement that first enabled doctors to consult via telehealth to patients at greatest risk of the impacts of COVID-19 was, over the matter of days, expanded to more consultations with more patients for general practitioners and other medical specialists. Telehealth measures that the AMA worked with Health Minister Greg Hunt to establish are up and running. More than 125,000 consultations were conducted by phone or video on the first day of Medicare Benefits Schedule backing. There will be many more improvements to our health system that emerge from our fighting the war against COVID-19; one of them will be the acceptance of telehealth as an integral, common-sense and economically viable element of the Australian health system.

Another essential weapon in our arsenal is personal protective equipment (PPE). This issue has been complicated by questions about the efficacy of some equipment and who should wear it; about whether masks are necessary in public; about what elective surgery should be performed in the face of PPE shortages. Our efforts in fighting for more PPE have been directed solely at ensuring our members can do their jobs safely, without increasing the risk to themselves and, eventually, to their families. We have made no excuses for our stubbornness in this space.

It became increasingly clear as COVID-19 devastated towns and regions around the world that Australia must be ready to deploy as many hospitals as possible to provide care for infected patients and for other sick and injured people. This required extremely complex negotiations between state and Federal governments – and with public and private hospitals, private specialists, insurers and others – so that our private hospitals, medical practitioners and other healthcare workers are aligned in the war against COVID-19, without long-term impacts on our members' financial security.

Similarly, it was clear that Australia would need more doctors and nurses, and the AMA has been instrumental in conversations with the government, universities and other groups to enable medical students, junior doctors and retired doctors to support the health system in ways that do not compromise their health, safety or career progression.

It was a shock to learn that life insurers were intending to withdraw coverage for medical workers who become ill or die due to COVID-19. I personally took this on – including with some very pointed remarks on the ABC – and demanded that should this be the case, Australian governments must introduce 'death in the line of duty' compensation. There have been very positive outcomes.

In the past couple of weeks, I have been urgently leading work to ensure that electronic prescriptions are available and can be delivered and monitored effectively and safely. Introducing electronic prescriptions was the logical next step to bringing in telehealth consultations, which we fought for to reduce the number of unnecessary physical transactions with patients. Such a major advance in doctor-patient care was achieved in this pandemic in just a few days, rather than in the years of old.

These are some of the outcomes of countless phone calls, zoom conferences and email trails. There has been the doubling of the Practice Incentive Payment that is supporting practices that employ tens of thousands of receptionists, nurses, and other ancillary staff to keep their doors open, and our insistence that our members be eligible for government business support initiatives such as JobKeeper incentives. We have worked quickly and collaboratively to introduce measures that limit the number of people visiting practices for driving assessments and avoidable face-to-face consultations. And along the way, we have offered our support to ensuring that state and Federal governments offer clear, calm, evidence-based messages to their audiences.

This pandemic has triggered the biggest realignment of the health system in a short period that we will likely ever see. It is a challenging time for all of us, but one in which change has occurred through each of us asking what can be done rather than being stuck on what can't. I am proud to be a member of the AMA, which has shown itself to be a leader as our collective forces assemble and our selfless members head to the frontline.

Photo: The Southern Cross

When change is the constant

BY A/PROF WILLIAM TAM

Many things changed almost in an instant.

The RAH underwent what seemed like a major makeover. It is, after all, the designated COVID hospital for South Australia. There are cordoned-off areas, closed retail outlets and the omnipresent hand-sanitiser stations. Not to mention reminders to observe social distancing rules. The east entrance to the hospital is closed and the food court is but one shop. Even the soothing music from the grand piano at the entrance foyer has ceased.

There is a pervasive sense of urgency, fuelled by the recognition that things will likely get worse before they get better.

With the declaration of the pandemic, we truly entered uncharted territory. Hospital staff have, however, genuinely embraced this challenge with gusto. Despite the uncertainty, we have been willing participants in change, and there is a feeling of unity and optimism as we make the necessary adaptations.

Of course, it has been a struggle at times. Overall, though, healthcare workers have stepped up to work together to combat the unseen enemy. We've all had training to don and doff PPE safely, had our N95 mask fittings, and most recently, our flu vaccinations. We receive daily updates on email, SMS, and the occasional face-to-face meeting. We were delighted when the Premier graciously offered free car parking during the Easter long weekend.

Zoom, Webex, Teams and GoToMeeting have become buzzwords. Grand rounds and outpatient services are now held virtually. Online multi-disciplinary teams (MDTs) are thriving, even flourishing. Sadly, registrars and fellows no longer attend procedure lists. This has become the new norm, at least for now.

Mood of late has been somewhat upbeat. We seem to have flattened the curve. We also no longer hear of ramping or bed blocks. Though workload has changed because of the national strategy to restrict non-urgent procedures, the patient-centric focus has never wavered. The RAH is admittedly no stranger to ramping down, having done this in the recent past. Only this time around, we're not working to a known timeline.

On a personal note, the only casualty of these restrictive measures has been our departmental Journal Club nights. Traditionally hosted by a consultant in their abode, complete with generous servings of cheese and the optional glass of wine, we have yet to find a solution to suit the 20 or so participants. Perhaps Zoom will come to the rescue. It'll be my turn to host in June – we'll wait and see.

A/Prof William Tam is the Immediate Past President of AMA(SA) and a gastroenterologist at the RAH.

Ageing in isolation

BY DR JANE HECKER

If you think you have problems resulting from the COVID restrictions and changes, then spare a thought for the elderly!

Members of our older population are generally more isolated currently than the rest of us. Often living alone, or with an ageing partner, many have a caring role with increased carer stress due to social isolation. Family stay away, concerned for safety. Life, which may have already been difficult due to physical and mental impairments, is harder without practical and emotional support. Some people have cancelled aged-care support due to fear of infection risk and most community group activities have been shelved. Older people at home are less mobile; inactivity, with a background of less strength and balance reserve, leads to falls and injuries. Older people are in the main less 'tech savvy' (and I could include those of us in late middle age in this group!), and less familiar and competent with the myriad of social media connection platforms that allow some level of ongoing connectivity for the younger population. Community support for older people could be ramped up using many newly unemployed.

For those who are unfortunate enough to be in hospital (mostly older people) visiting is limited or non-existent, denying support when need is greatest. Residential care facilities are generally allowing no visitors which (while understandable in the current climate) is extremely distressing for both residents (many of whom are not capable of understanding the reason for the isolation and lack of family visits) and family members who are unable to provide reassurance, love and affection. In addition, the absence of family contact that calms residents who may have cognitive impairment, restlessness or agitation increases the difficulties for professional carers. Phone or other media contact is impossible for many of these residents due to confusion, hearing or visual impairment, and because the carers who could help with this have their time already stretched managing residents' basic needs.

Social isolation has a heavy emotional toll for older people with health issues. The uncertainty of the future isolation period weighs heavily on those whose life expectancy is limited. Many feel that life is not worth living if the rest of it is to be spent in social isolation. I have certainly heard this expressed to me on more than one occasion recently. For those with terminal illnesses, family from interstate or overseas are unable to visit and patients are no longer able to share last weeks or months in the company of family and friends. Even funerals are limited, impacting on the ability to celebrate lives and grieve together for loved ones.

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A pregnant pause

Women planning mid-2020 deliveries are facing all the ‘normal’ pandemic concerns and more, writes Dr Linda McKendrick.

DR LINDA McKENDRICK

© iAleksandra Golubtsova, iStock

‘Surreal’ and ‘weird’ are the words most often being used to describe the world we are in now. Like all other practitioners, obstetricians are confronting and managing scenarios we have never faced before. We are planning for as many scenarios as we can and learning from our colleagues in other countries who have had far more cases than Australia has at this moment in time. These colleagues are sharing their experiences and warning us of the pitfalls that can occur. As I write this there has not been a pregnant woman with confirmed COVID-19 in South Australia; however, that is likely to change at some stage, and we must be ready.

Our pregnant women are anxious and are aware that this is a new virus and we have little data to work with. From what information we have, it appears pregnant women are no more susceptible to the virus than non-pregnant. They are also no more likely to be seriously ill than the general population – but data is limited, and we know that pregnant women catch the flu more often and are more often seriously ill with the flu, so we are erring on the side of caution. All pregnant women have been advised to have their flu vaccine as soon as possible. The UK’s Royal College of Obstetricians and Gynaecologists (RCOG) guidelines list pregnant women as ‘vulnerable’ to COVID. The RCOG is also concerned about a possible increase risk of severity of the illness in the third trimester and have clearly stated that pregnant women in the third trimester ‘should pay particular attention to social distancing and minimise contact with others’.

There is no data regarding teratogenicity or increased rates of miscarriage with the virus, but there may be an increased risk of preterm birth. There is some data to suggest an increased risk of growth restriction after a woman recovers from the virus and thus an ultrasound to assess growth two to four weeks after the infection has resolved is advocated.

There appears to be an increased rate of fetal distress in labour, so women who have had COVID will be advised to have continuous fetal monitoring in labour. Telemetry is a radio-signal that allows the women to move within the room in labour but still have fetal monitoring. Fetal scalp electrodes should be avoided. There does not appear to be any reason to change the proposed mode of delivery, other than for obstetric reasons or to maximise maternal resuscitation. Entonox is not available for labouring women in South Australia, but this decision remains under review. Water births are also contra-indicated for COVID-positive women.

Most hospitals now only allow one named visitor in labour and postnatally. This is a surprise bonus for our women; they are better rested and are able to maximise the postnatal education available when there are fewer visitors. Delivering a baby vaginally is an aerolising situation, so staff at delivery will be wearing personal protective equipment (PPE), gowns, surgical masks, goggles, visors and gloves. N95 masks will be reserved for suspected and COVID-positive women. At present there is discussion regarding keeping the baby with a COVID-positive mother. Many, including the World Health Organization, advocate the baby staying with its mother and breastfeeding if possible – but the mother will need to wear a mask to reduce transfer of COVID to the baby while feeding, and wash her hands before and after feeding. In the early days of the pandemic in China, babies were immediately separated from their mother for 14 days. It may well be a decision to be decided case by case.

There are changes to the way we perform antenatal care. Sadly, we are advocating no children or partners to attend antenatal visits at the present time. Most obstetricians are now using some telehealth, but there is still a minimum number of face-to-face visits required to assess maternal and fetal wellbeing (the RCOG recommends a minimum six face-to-face visits). Some women can monitor their own blood pressure at home, but fetal growth requires a symphyseal fundal height measurement or an ultrasound. Ultrasounds are also being reviewed, both in frequency and how they are performed. Sonographers unfortunately are suffering higher rates of COVID because they are in close contact with women while performing ultrasounds, and most ultrasounds take longer than 15 minutes to obtain adequate views. There are some newer ultrasound techniques that mean some of the images can be computer generated, which can reduce scanning time. Growth scans have been reduced from three to two per pregnancy, unless otherwise indicated. Instead of two-hour glucose tolerance tests at 28 weeks, a fasting glucose assessment is being ordered so that the women do not have to spend two hours at the pathology laboratories.

In our private practice we have changed our working days so that only one consultant is in the office on any one day, limiting our exposure to each other. Telephone consults mean less exposure for our staff as well as our pregnant women. Our women are asked to remain in their cars until we call them to enter the rooms when (usually) no other women are present. We are talking to women in their cars before their appointments so that any prescriptions or blood test requests have been printed or sent electronically when they attend the rooms. Unfortunately, we must greet women with a questionnaire about where they have been in the last two weeks, and their temperature is taken on arrival. The mental health of our pregnant women remains a priority; many are anxious about the unknown repercussions of the virus and about the changes in their daily life. Help is always at hand.

Women are encouraged to attend if they feel something is not right with the pregnancy – we are advocating they should not be afraid to attend the hospital for usual pregnancy problems; for example, decreased fetal movement always requires a visit to the hospital or rooms to assess the fetus, usually with a cardiotocograph (CTG). Women are requested not to attend if they are unwell, but to contact the practice so we can decide how they are best assessed. Women who are COVID-positive may have their appointments or ultrasounds deferred until they are symptom free, if it is safe to do so. If the appointment cannot be delayed then a dedicated time, staff and entrance and exit will be arranged to minimise the risk of transmission of the virus. Women who are self-isolating because family members are isolated will where possible also need to delay their appointments by two weeks.

Hospitals will need to be ready for the woman who becomes symptomatic 24 hours after delivery – this has involved lots of intricate planning involving nursing, administrative, kitchen and domestic staff who come into contact with these women on a daily basis. Staffing will need to be reviewed, probably on a day-to-day basis since it is expected that 20 per cent of the workforce will be excluded from working either ill or following exposure. Hospitals are also preparing for suspected COVID women. Staff are practising donning and doffing PPE – doffing correctly is incredibly important because it is the mostly likely time for contamination. Staff have also had to attend for fit-mask testing to ensure the N95 mask provides a firm seal. Some gynaecologists who have had their elective surgery severely reduced have offered to be credentialed to perform caesareans sections, a procedure they may not have performed for several years.

COVID has provided lots of challenges for our women and the staff and doctors who care for them. I am heartened by the way pregnant women have embraced the challenges and have coped with some of the disappointments that have been caused by COVID management protocols. As always, we are trying to provide the best possible care for our women in these difficult circumstances.

Dr Linda McKendrick is an Adelaide obstetrician and gynaecologist.

In appreciation

AMA(SA) members have joined colleagues across the health system to care for patients with COVID-19 and battling other health issues during the pandemic. Thanks go to everyone across the state – some of whom are pictured here – whose services have been and continue to be essential for the health and wellbeing of all South Australians.

(Photograph: Matt Turner, Advertiser Newspapers)

Ageing in isolation

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The changes in standard medical care have negative impacts for older patients. The provision of new item numbers for phone and telehealth, including those for complex medical patients and geriatric assessment, has been helpful but these are not a satisfactory replacement for personal consultations. Physical examination is not possible, and the interaction feels remote and less supportive to the patient. Patients are frightened to attend and ‘business as usual’ is neglected. While the surgical beds may be unoccupied, the demand for medical beds in the public system is increasing and the daily medical admissions including the ‘COVID unit’ are putting strain on the doctors and the system.

We are lucky in South Australia to have used foresight and planning for the challenges ahead, but we all need to work together to support the system, and our patients, particularly the elderly.

Dr Jane Hecker is a geriatrician in private practice and in the RAH’s Department of General Medicine.

Wake up and strum your guitar

The disruption caused by COVID-19 could have a host of unforeseen benefits, if we let ourselves recognise them, writes Doctors' Health SA medical director Dr Roger Sexton.

DR ROGER SEXTON

Thank goodness for my guitars in the new COVID world order!

They hang on the wall of my study like silent, patient and loyal friends waiting to be invited to a party. I have been drawn to them lately, finding great delight in being musically creative with them.

Why is this? Perhaps it is the endorphins, acting as a counter to COVID-induced sympathetic overdrive! Maybe it is the pleasure of creating some concordant musical order from a new chaotic discordant world! Maybe it is just that now my diary has these strange clear spaces and my less cluttered cortex has some free synaptic time to do it!

Freewheeling on the guitar is in stark contrast to our work as doctors. My travels around the profession have shown me the extraordinary depth of talent and creativity within it. It is abundant. We all know someone who is artistic, musical, inventive, an original designer, literary, theatrical, entrepreneurial and so on. Yet for a creative bunch, we chose a very constrained profession. Each day, we must abide by and adhere to so many things. Consider evidence-based medicine, clinical guidelines, the Medical Board code of conduct, lifelong continuing professional development (CPD), college training pathways, the Fair Work act, to name a few. Such constraints need a creative antidote.

We are also expected to meet the needs of patients, staff, work colleagues, administrators, employers, our colleges, governments and others.

In addition, we try to fulfil our other roles in life (which by the way make it so much richer!). Medicine can squeeze everything out if we let it: time with family and non-medical friends, time enjoying our other roles and quiet time for ourselves. It is easy to collude with our self-sacrificing inner self and justify to ourselves and our families the inarguable importance and primacy of our work.

This is in the setting of our 24-hour day (aah, if only we had 26!). Consider your typical day and how you allocate it across the following:

- personal time for sleeping, meals, exercise, ablutions, travel, personal relationships, domestic task, creative pursuits and quiet reflective time, social dinners, entertainment
- professional roles, which include academic, teaching, research, administration, clinical medicine, CPD events, college activities and running our businesses.

The days are full. The white pages of the new diary quickly turn black. A thin layer of dust starts to gather on the first fret of your neglected guitar!

And then, along comes COVID-19.

This is a disruptive external shock which has changed our lives personally and professionally. The impact on doctors has been dramatic. Examples I have seen include:

- doctors stressfully engaged in urgent changes to the modus operandi of their practices (general practice especially), creating new infection control processes and systems within the practice to protect staff and patients and conversion of work to telemedicine
- maintaining business continuity where the infrastructure disallows 'usual practice'
- rural doctors experiencing greater isolation as social distancing and unnecessary travel between regions is imposed
- cancellation of elective surgery and knowing this will have consequences for patients (e.g., the possibility of cataract patients falling while awaiting surgery)
- significant short-term income reduction for surgeons, radiologists, locums and special interest GPs
- disruption to undergraduate learning and highly valued rural placements
- changes to clinical roles for SA Health-employed doctors directed into unaccustomed roles to assist the anti-COVID effort
- deferral of college examinations and the impact on already exhausted, dedicated and self-sacrificing young doctors
- anxiety triggered by constant COVID updates and media overload.

COVID-19 has also triggered a social and professional change that has been welcomed. It has stopped the hectic mix of work, travel, dinners, meetings and other occasions that characterise the lives of many doctors. For doctors who have felt trapped in their current roles, COVID has offered the chance of a 'gap year'. If you wanted to step off the treadmill for a while and experience what others with balanced lives are doing each week, this is it.

Grab it. Talk to your accountant. You may be very surprised how the numbers stack up. I have heard one say, 'Doctors don't have an income problem, they have a spending problem!'.

COVID has given us all reason to reflect upon and rediscover what is important. Family, friends, simple good food, the importance of a safe, warm and welcoming family home, the importance of kindness and social connectivity, the importance of hobbies and interests and creativity, the need for quiet reflective time away from the demands of others.

Above all, let's celebrate how society has turned to doctors for comfort and advice at this time. As doctors we must speak with kindness and optimism, and act as leaders who are respected and trusted at a time when fear is abundant. Like the strings of my guitar, seek resonance with those around you in your workplace and at home.

COVID-19 is a once-in-a-lifetime event for us personally and for our profession. Some doctors will thrive and others may just tread water. The need for collegiality has never been greater. This is especially a time for doctors to aspire to personal and professional growth.

It is also our profession's opportunity to reaffirm its place as the leaders of the Australian health system. It has been truly heart-warming to see our doctor leaders standing side by side with the Prime Minister and the state Premiers defining what must be done. What other profession has been asked to do this?

Society has been looking for clear advice they can trust. Doctors have delivered it. Congratulations to our medical officers who have spoken to the people and given such clear advice.

Personally, I won't forget the simple parental advice that has come from the PM and Chief Medical Officer to 'Just stop it!'. Quote of the year.

I will abide by that, but I need my guitar.

Staying in the (COVID-free) zone

No matter what the song says, writes Dr Michelle Atchison, this is a time to resist bad habits.

DR MICHELLE ATCHISON

There's a lot of advice coming at us from all areas about how to manage our mental health. Kochie on Sunrise tells us what to do, there is a variety of online services such as Beyond Blue available, and the South Australian Government has a COVID-19 mental health hotline you can call.

However, doctors are never very good at using services to support their mental health, and tend to rely on colleagues or support from online forums they are involved in. It is interesting to see the number of doctors on Facebook and Twitter commenting how they are finding the going tough.

These are unprecedented times and already we can see that this period will provide an opportunity for research into the physical, mental and emotional impacts of enforced isolation. Studies will tell us later what was most effective and what didn't help people cope with this sudden requirement that we spend all our time at home. Research into how doctors have coped with the sudden change in how we practise would be welcome. For some of us it has been the rapid change to telehealth. For those in the public system, there has been the very real fear of catching COVID-19 or taking it home to family members and anxiety about whether there is enough PPE. For the proceduralists the sudden loss of elective surgery has been a major challenge.

Sitting where we are in the midst of it, I would like to comment about what we should not be doing, and some of the bad habits that can creep in at a time like this.

First, alcohol. Don't drink more, just don't do it. Doctors are well known to use alcohol to cope with the stress of their jobs, and this is a time of extraordinary stress. We have all been asked to change the way we work, and many of us are at the frontline of exposure to the COVID virus and all the anxieties that it brings. Many of us are rapidly upskilling to technology, those in private practice have taken great hits to their income, and some procedural specialists are not working at all. It is so easy to turn to a bit more alcohol to self-medicate that anxiety and it is the most socially acceptable way of doing so. The problem will come as that 'bit more' becomes 'a bit more on top' and so on. As well as the physical health consequences, alcohol does not help relationships. It isolates you from those around you and can make any small argument into a larger one, and this is a time when many relationships are stretched anyway.

Second, alcohol. See above.

Third, filter. Managing the overload of COVID information will help your mental health. Doctors have a double whammy for information. We are saturated by news on media and social media, but we are also trying to understand the scientific literature, read about drugs that may be helpful, keep up to date on guidance around PPE, and absorb information from our hospitals and colleges. By all means keep up to date, but give yourself some down time about COVID information. Don't check your emails and social media before bed, give yourself a good two-hour COVID information-free period before bed. Be very sure about any scientific information that you put up on social media and try to support others who are raising comments. If someone you know posts about feeling anxious, check on them personally, not just by liking the post.

Try not to over self-isolate. After a busy and stressful day, it is easy to withdraw and need your own headspace. Remember that those around you are likely anxious, too, for you and for themselves. Consciously try to bring yourself out of that cocoon that shields us from anxiety, and keep emotionally connected with those close to you. Talk about what happened in your day and ask them about theirs.

AMA(SA) Vice-President Dr Michelle Atchison is a psychiatrist in private practice.

Calm in a COVID crisis

JADE PISANIELLO
STUDENT NEWS:
ADELAIDE UNIVERSITY

Being a medical student is inherently challenging. It is easy to feel like an inconvenience to the provision of care. We can believe we have nothing to offer. Our sense of belonging at the hospital is dependent both on our team and our patients. Sometimes we stand at the back of a ward round wondering if anyone knows our names; other days, we are the ones comforting crying patients because they have no one else to turn to. We are humbled by the generosity of our patients, who teach us so much. They *nod* through our circular histories, smile through our rusty physical examinations and encourage us to 'just have one more go, love' with the jelcos. As a student community, we are watching with interest and concern the outcome of this unprecedented crisis, for ourselves, our mentors and our patients.

Many students indicate that the challenges of medical school are offset by the sense of community and fun provided by the Adelaide Medical Students' Society. Sadly, we had to make the difficult decision to postpone all our social and educational events when the COVID-19 crisis hit. When we made this announcement, the government had only just made a recommendation to ban events over 500 people – despite this advice, we decided to act with an abundance of caution. Although medical students might not be the ones prescribing lifesaving medications or leading a code blue, we do still have direct contact with vulnerable populations, including the elderly and the immunocompromised. It was clearly irresponsible to host non-essential gatherings in these times.

So, we've had to make changes. Sixth-year students are not travelling overseas for electives. Our fifth-year students completing the paediatric and obstetric-gynaecological exchange in Aarhus, Denmark, flew home. Sadly, most students across years 3-5 of the program have been advised that attending placements at hospitals is not appropriate for the foreseeable future. For the 2021 cohort of interns however, thanks to the efforts of dedicated Adelaide University, Adelaide Rural Clinical School, NALHN and CALHN staff who recognise final year students as essential members of the medical workforce, the current year 6 students recently recommenced placements across Adelaide.

AMSS members have responded with understanding and compassion, and demonstrated their sense of responsibility, leadership and selflessness, during this difficult period. It is with pride that I reflect on how we have remained calm in a crisis. I feel privileged to represent the AMSS and work with the Adelaide Medical School during this uniquely challenging time.

Not the Corona(s) students are used to dealing with ...

LIAM RAMSEY
STUDENT NEWS:
FLINDERS UNIVERSITY

I was hesitant to write anything about COVID-19 for my *medicSA* submission this month. I personally am saturated with COVID-19 news. In my year as president, I intended to try and write thought-provoking pieces that made 'wiser' (older) clinicians reflect on their student days. But I do feel a responsibility to shine a light on how COVID-19 has affected the student experience. I recognise that the pandemic is a much bigger problem than the quality of student placement, but our workforce depends on a constant supply of competent, empathetic and lively junior doctors. Ensuring we maintain some placement quality and quantity is paramount in this.

COVID-19 has brought a large disruption to student placements Australia-wide. In my previous piece I discussed how infrastructure restrictions impede clinician-student teaching. This now feels small and irrelevant; instead, a self-replicating, non-sentient protein has attempted to place PPE, hospital re-structuring, staff-shift changes, social distancing and university closure between the eager student and the knowledgeable clinician.

As students and junior doctors, 'imposter syndrome' is well described: it's a sensation of feeling you don't belong. COVID-19 has materialised this fear, so that in the eyes of many we really are 'non-essential'. Principally I disagree with this point, albeit we've needed some additional safety restrictions around clinical placement. However, placement must continue. It's fundamental to ensuring the longevity and stamina of our workforce in a post-COVID-19 world.

The Flinders Medical Student Society has conducted informal surveys to better understand the student experience. Operational changes have affected placements across Australia, including specialities now not accepting students, the introduction of week on/off shifts, theatre closures, PPE restrictions, country emergency departments closing and clinics moving to tele consults. These structural changes are out of our control, but the way medical students are treated is something we can control.

An evolving component of the disruption to our training is the manifestation of consultant and leadership stress. This has been seen in doctors' unilateral decision-making, often with students' best interests at heart. However, rhetoric that has students dehumanised so we become 'vectors', or as a function of risk, is deeply disengaging. Universities Australia-wide have been steadfast in keeping students on placement. So when we label students as non-essential it is conflicting, it curbs enthusiasm and it absolutely diminishes the passion to learn.

With increasing uncertainty in their workplaces, more and different pressures in leading units, and many questions left unanswered, it is foreseeable that senior doctors would be under pressure. But we all have a duty, no matter our rank, to combat these stresses and to ensure we communicate effectively and kindly. We want students to be excited about coming into the workforce, not dreading it.

While these are difficult times for all healthcare workers, please don't forget the students. Treat us well and nurture our enthusiasm to learn and participate in practical and safe ways. Regardless of how COVID-19 develops, in eight months the system will need strong, caring interns who are not burnt out or disenfranchised. We all play roles in developing the future of our workforce.

I would like to highlight that I have been blown away with the leadership demonstrated at Flinders University and Flinders Medical Centre. There has been tremendous guidance and support, and I have personally already learned an incredible amount about what it means to be a leader from so many of you.

Booking apps could be discriminatory

The Equal Opportunity Commissioner says details needed in online booking forms could prevent people accessing essential healthcare.

The mandatory mobile phone field in online medical practice booking forms could be unwittingly discriminating against many of the people they are trying to help, says South Australia's Commissioner for Equal Opportunity.

In a letter to the AMA(SA), Commissioner Niki Vincent notes that booking apps such as HealthEngine, HotDOc and Appointuit include mandatory mobile phone fields, which mean that people without mobile numbers cannot book.

'This requirement has a disproportionately adverse impact on people with a hearing impairment or who are deaf, who may not have a mobile number and who cannot easily phone to make an appointment,' Dr Vincent wrote.

She said that while online booking facilities could be a highly inclusive way of booking appointments for people with hearing impairments, the requirement for a mobile phone number was unnecessarily restrictive.

It could lead to a complaint under the *Equal Opportunity Act 1984 (SA)*, Dr Vincent says.

Most online booking facilities are provided by software companies. Dr Vincent has urged medical clinics, as the customers, to ask their health engine providers to reconfigure their apps to enable patients without mobile phones to book appointments.

The Act provides the Commissioner with powers to educate the community with the aim of eliminating discrimination and she has approached the AMA(SA) to help make practices aware of the potential for discrimination.

Doctors may wish to approach their bookings service providers to ensure that their practices are not discriminating against people with hearing impairment or who for other reasons do not possess mobile phones.

Towards zero tolerance

The AMA(SA) Culture and Bullying Summit attracted leaders from across the health sector – but the work has just begun.

Politicians, government officials, administrators and partners from across the health system joined doctors and medical students at the University of Adelaide's Health and Medical Sciences Building on 29 February for the AMA(SA) Culture and Bullying Summit.

The Summit followed Dr Moy's appearance with AMA(SA) CEO Dr Samantha Mead before the Parliamentary Inquiry into Workplace Fatigue and Bullying in South Australian Hospitals and Health Services on 13 September 2019. There, Dr Moy provided data, anecdotes and other information demonstrating the extent of bullying and harassment in the South Australian public health system.

Dr Moy told the Committee that the AMA(SA) would stage a 'bullying summit' in early 2020 at which South Australian health sector leaders would identify bullying issues and causes and demand that 'bullying must stop'.

By 29 February, bullying was not the only critical issue confronting SA Health. Yet South Australian Health and Wellbeing Minister Stephen Wade found time to open the Summit, supported by the woman whose face would soon be one of the best-known in the state: Chief Public Health Officer Associate Professor Nicola Spurrier. And more than 100 of the leading health and medical minds and leaders in South Australia spent a precious morning listening and contributing to the Minister and the speakers who followed him.

Dr Hannah Szewczyk, chair of the AMA(SA) Doctors in Training Committee, began by outlining 2019 Hospital Health Check statistics to indicate the scale of the problem. Dr Szewczyk reported that South Australia's results in the survey of junior doctors mirrored those of other states in recent years on workforce factors such as access to leave and professional development opportunities, rostering and overtime, and bullying and harassment.

In particular, she noted that:

- the Royal Adelaide Hospital (RAH) performed worst on all measures
- more than half of junior doctors working in the three major teaching hospitals (RAH, LMH, FMC) in South Australia reported personal experiences of bullying
- in most cases, the perpetrators of bullying were senior doctors
- many junior doctors aren't taking sick leave when they should.

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, 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.

The statistics formed a strong foundation for what was to follow. MIGA senior solicitor Tim Bowen noted that health professionals recognise the link between unprofessional behaviour and threats to patient safety and wellbeing, with bullying, harassment and 'poor culture' potentially having significant effects on a workplace and those in it – and ultimately placing patients at risk.

He said that from a medical-legal perspective, however, the contributions and impacts of bullying and poor culture are not always obvious or measurable. 'Too often,' Mr Bowen said, 'the ramifications are recognised after something goes wrong.'

Mr Bowen said solutions must address the underlying fatigue and workplace pressures, outline and demand adherence to acceptable culture and behaviour, and form part of broader initiatives to recognise the importance of doctors' health.

A/Prof Christine Lai of the Royal Australasian College of Surgeons (RACS) focused on the actions RACS has introduced to combat bullying, harassment and discrimination in the profession since a 2016 survey found 62.5 per cent of trainees who left surgery had experienced bullying.

Professor Michelle Tuckey

A/Prof Lai outlined key actions of the RACS that have followed the findings, including introducing mandatory 'Operating with Respect' online and face-to-face modules; memoranda of understanding with university medical schools, hospitals and other partners to address the issues in training and education; setting gender equity targets for training and on committees and boards, and a centralised complaints handling process that includes monthly reporting to key audiences.

A/Prof Jill Benson, Clinic Doctor at Doctors' Health SA, pointed out

... 'When workplaces aren't great, outcomes are reduced for health consumers' ...

that anyone can behave badly in the right – or wrong – circumstances or environment. 'We need a working environment that allows people to be vulnerable, and encourages courage and creativity, not be afraid of shame and blame,' A/Prof Benson said.

She referred to 'the systemic factors' that lead to burnout and fatigue and can be the root cause of bullying – a theme that was to become increasingly prevalent throughout the morning. The 'Risk Audit Tool' to which she referred was soon a term on everyone's lips – including on those of AMA(SA) President Dr Chris Moy, who wrapped up the session's proceedings before introducing keynote speaker Professor Michelle Tuckey.

Findings and fixes

Professor Tuckey, of the University of South Australia's Centre for Workplace Excellence, has become increasingly focused on identifying sources of workplace bullying since joining UniSA in 2005. She 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 a bigger problem: the workplace systems, structure and processes.

AMA(SA) President Dr Chris Moy led discussion at the AMA(SA) Culture and Bullying Summit, which attracted doctors, students, media and leaders of the SA health sector including Health and Wellbeing Minister Stephen Wade (bottom row, second picture from left).

'Bullying is the tip of the iceberg,' Professor Tuckey said. 'I want to find and fix what's at the bottom.'

She said the risk audit tool had been developed to do the finding. It asks staff questions about their workplace – about their roles and tasks, rosters and hours, leave, training and professional development, communication mechanisms, and other factors. The fixing requires 'designing out' the factors that cause stress, fatigue, resentment and other characteristics of 'poor workplace culture' – and can start with small, quick wins.

After the break, Dr Moy introduced a panel including Professor Tuckey and the other speakers, as well as Doctors' Health SA's Dr Roger Sexton and Julia Overton, CEO of the Health Consumers Alliance of SA, to answer audience questions.

What we seem to be saying, Dr Moy said, was 'if you give people reasonable hours, manage their performance respectfully including bad behaviour and provide positive leadership the likelihood of bullying is reduced'.

'Bullying occurs because the culture and the workflow aren't right,' he said.

Ms Overton said that when considering impacts of bullying on consumers, discussion must include both clinical outcomes and 'what consumers want as outcomes'.

'We need to look at the outcomes they want achieved and we know that they are hidden when there is a culture in the workplace of bullying and harassment ... that when workplaces aren't great, outcomes are reduced for health consumers,' Ms Overton said.

'We also know that when health consumers are engaged in the activities of the health service that the workplace culture improves.'

With the discussion turning to peer-to-peer interventions and bottom-up appraisals, Dr Szewczyk asked that assessments be anonymous, to eliminate the potential for repercussions. Dr Lai explained how the anonymous RACS complaints hotline works to identify potential issues and individuals.

DiTs Committee deputy chair Dr Jemma Wohling highlighted that bullying so often is the result of 'good people having bad days'. 'It's about trying to be reflective in your own behaviour and your own responses,' she said as if addressing senior doctors, 'and being really honest – "I'm really sorry, I'm really stressed right now. Sorry if I'm being short."

'That will excuse a lot of things.'

Board responsibilities

A comment from Women's and Children's Hospital LHN Chair and former SA Health CE Jim Birch led discussion back to organisational systems. 'At the multi-national company that I worked for (after leaving SA Health), if we had results like those that I just saw up on the screen we would go broke,' Mr Birch said.

He said he found the private sector 'was far more focussed on the wellbeing of staff than the public sector ever was'. 'In any other corporation', he said, boards would be 'all over the health and wellbeing of staff'. He expressed shock at the Hospital Health Check figures, which he said were 'simply not tolerable', and advised that each LHN have health and wellbeing officers to manage issues in its jurisdiction.

It was a line emphasised when Dr Sexton responded to a question about what could be seen as the prohibitive cost of introducing staff and resources to counter bullying.

'Board directors can go to jail if there is death on site,' he said. 'So, the apprentice falling off a building because of poor orientation or poor work preparation and supervision, versus the intern who jumps off because the workplace is too difficult and there is bullying – they are both events and costs for the board of that company.'

'We immunise people,' added Dr Moy. 'We know the benefit and we know the cost of immunisation. What we need to do is immunise the workforce. Invest in them, to prevent the cost at the end in terms of workforce and patient safety.

'If this was a disease, we would have cured it.'

'If this was a disease,' added A/Prof Benson, 'we'd have a vaccine.'

A report from the Summit, including recommendations to the Minister, is being prepared.

The AMA(SA) congratulates the 2019 graduates of the Adelaide Medical School. We offer each of you our best wishes for your careers and your lives in this most important of professions.

2019 University of Adelaide MBBS Graduates

AMA(SA) President Dr Chris Moy presents Tom Gransbury of Adelaide Medical School with the AMA(SA) Student Prize

Ranindu Abegunawardene
Luke Allen
Erica Ang
Naukhez Asif
Vinay Athreya
Mahanoor Baig
Olivia Bampton
Meghan Barnett
Gemma Barrow
Emily Beck
YongZhi Beh
Charlotte Blacketer
Patrick Brown
Zachary Bunjo
William Butterfield-Rossi
Debajyoti Chaudhuri
Rebekah Clark
Gabrielle Coard
Maddison Cooling
Daniel Cooper
Alice-Rose Crawford
Carrla De Angelis
Peter De Cicco
Jee Do
Montgommery Do-Wyeld
Elizabeth Dooley
James Elix
KwanYang Ewe
Alexander Ewers
Natalie Fisk
Alannah Frazzetto
Rhona Fulton-Drendel
Evan Garrett
Grace Goodwin
Thomas Gransbury
Natasha Gray
Luke Halliday
Emily Hatwell
Anja-Michaela Hentschke
Mrunal Hiwase
Sonia Huang
Emily Humphries
Ying Hung
Lian Huynh
Adil Isaac
Rohan Jacob
Sarah Jaensch
Anusha James
Bola Jeong
Charis Johnson
Dione Jones
Madeleine Jones
Bridget Joseph Xavier
Cutie Kannampuzha
Sanjana Kasthurirengan
Casey Knight
Joel Song Kai Koh
Ben Koszegi
Melissa Kuiper
Alexander Lai
Esther Lam
Victoria Langton
Eleanor Last
Niamh Lavender
Natalie Xie Pin Lee
Luke Lehmann
Dexter Leong
Georgina Lewis
Lusa Li
Brenda Yuen Lim
Matthew Lim
Richard Lin
Katherine Lissner
Melissa Liu
Yi Loo
Lincoln Low
Hank Ly
Nicholas Lynch
Jessica Mashado
Fiona McCalden
Jemima McKenzie
Georgia Mead
Bryan Homi Mehta
Edward Mignone
Nicole Milham
Jessica Mitchell
Cara Moffa
Shirrin Mougamadou Yaccoup
Ishraq Murshed
Aung Naing
Francis Nathan
Olivia Nguyen
Huu Nguyen
Amalan Nirmalaraja
Amy Noll
Niamh Noonan
Toon Yang Ong
Si Ling Ong
Wan Chen Onn
Roger Parnis
Prajay Patel
Tim Phillips
Prabhatha Polwaththe Rathubaduge
Preshena Prem
Morgan Price
Kate Richards
Ignatius Rudd
Liam Ryan
Salma Salih
Holly Sandford
Angus Sarah
Nicholas Scott
Wei Hong Seow
Amelia Shanahan
Meghna Shelke
Isabella Simpson
Ashlee Smallwood-Simpson
Samantha Smith
Joseph Snyder
Tuan Yao Sob
Marina Spajic
Owen Streeter
Morgan Swearse
Hannah Wen Xiu Tan
Zhi Tan
Siao En Tan
Isaac Taylor
Karyn Tee
Patricia Ming Ho Ting
Joseph Kah Tneoh
Lana Tran
Andre Tran
Thuy Tran
Thu-Huyen Trinh
Alexander Tsymbal
Rachel Tymianski
Gabriella Venter
Derek Verhoeven
Sune Victor
Hua Lin Wang
Joseph Waugh
Amy Weber
Olivia White
Yue Hao Yang
Siu Man Yuen

The AMA(SA) congratulates the 2019 graduates of the Flinders Medical School. We offer each of you our best wishes for your careers and your lives in this most important of professions.

2019 Flinders University MD/BMBS Graduates

Jarrod Hulme-Jones of Flinders Medical School is awarded the AMA(SA) Student Prize by AMA(SA) President Dr Chris Moy

Abuoi, Arok
Alexander, Elizabeth
Anderson, Olivia
Atkinson, Lucy
Baker, Morgan
Baxter, Claire
Bekeris, Ryan
Benn, Edmund
Bonsu, Yaa Nimo
Booth, Alexander
Booth, Andrew
Bottos, Jude
Brazier, Lani
Brewerton, Callum
Buick, Michael
Carter, Alysa
Cavouras, Czenya
Chang, Sze Hong
Chin, Yixiu
Ch'ng, Brian
Cho, Guang Hao Gerald
Chua, Mei Yi Melissa
Cohen, James
Cox, Ashleigh
Dalrymple, Alice
Dimmock, Alyce
Dreimanis, Sonia
Dunne, Michael
Evans, Penelope
Evans Sanchez, Kathleen
Faulkner, Timothy
Fox, Nicole
Freeman, Scott
Ghataura, Anandpreet
Gillham, Alexis
Glass, Georgia
Gomez, Benjamin
Gott, Frederick
Grave, Laura
Gupta, Rajshree
Hancock, Diana
Hannam, William
Hariharan, Sumeela
Ho, Ezekiel
Hong, Jun Hao
Hulme-Jones, Jarrod
Jeffery, Jacob
Jeremic, Philip
Johnson, Katerina
Jones, Owen
Kachhvi, Zakerabibi
Kaur, Harleen
Kawakami, Kazuki
Kealy, Benjamin
Kearney, Damien
Kerr, Lachlan
King, Andrew
Kolovos, Antonia
Kuany, Thiep
Le, Minh
Leahy, Anthony
Lee, Jane
Liang, Zach
Lourens, Ernest
Low, Kuan Han
M Ghanesh Kumar,
Martis, Michael
Marx, Christian
McQueen, Georgia
McVeay, Christina
Moore, Katherine
Mullen, Dean
Newton, Alexander
Ng, Wai Yung
Noori, Zulaikha
Oates, Kim
Onggo, Jason
Oprea, Madalina
Osborne, Christine
Peres, Penelope
Phua, Ian Hong Andrew
Power, Harry
Pulford, Emily
Pyke, Thomas
Raza, Sundus
Razali, Nuralyah
Razmi, Norasyiqah
Ridwan, Denny
Ring, Daniel
Robinson, Timothy
Ross, Jacob
Rossiter, Jennifer
Rudolph-Stringer, Victoria
Ryan, Katherine
Scott, Hayley
Setiawan, Jennifer
Shaw, Stephen
Sires, James
Sladojevic, Nikolina
Stephens, Tenae
Strauch, Leah
Su Wai Tara, .
Tan, Zhi Yao
Tang, Matilda
Teoh, Jian Hung
Tessier, Kerrie
Tong, Chun Yin Brian
Trehan, Sharad
Turtle, Elizabeth
Urdevics, Erik
White, Roland
Wirth, Hugh
Wlodarczyk, Julian
Wormald, Jamie
Wouters, Belinda
Ye, Chen'En
Zahrooni, Shima

In good hands

AMA(SA) member Professor Ted Mah received a Public Service Medal in January for his many medical accomplishments. But he says he's just getting started.

When Flinders University Orthopaedic Surgery Professor Ted Mah sees a need in his chosen profession, he sets about trying to meet it – particularly if it means boosting access to education and health services.

It's this characteristic that drove him to study hand microsurgery and upper limbs with the best in the US about 30 years ago, when there was limited expertise in the area in Australia.

It's also behind the work that led to him being a 'surprised' recipient of a Public Service Medal in the 2020 Australia Day Honours list. The medal recognised his efforts to build an orthopaedic surgery unit in the rapidly growing northern Adelaide population in the 1980s.

It's behind his work to globalise surgical training through the Asia Pacific Orthopaedic Association (APOA), of which he is a former president.

And it led to his receiving the AMA(SA)'s Award for Outstanding Service in Medicine in 2019.

Professor Mah has a finger in so many pies it is hard to believe he has just two hands. As well as being active in the Flinders University College of Medicine and Public Health, he provides hand, elbow, shoulder and microsurgery services in Adelaide and is actively involved in research and administration.

He sits on six editorial boards, is the deputy editor of the *Journal of Orthopaedic Surgery*, and has more than a dozen prizes and grants listed on his university profile page.

He is often among the first to see potential need and to innovate in service delivery, in orthopaedic techniques to ensure value for money and in teaching – even in the push to study hands and limbs in the 1980s.

'I deliberately went to America to work at the Kleinert Institute, which is still a world-leading centre in hand and microsurgery, to learn about hand surgery, soft tissue management and micro-surgery, so I could fill the deficiency I felt in myself and bring knowledge back to the Australian population,' Professor Mah recalls.

'People don't appreciate how difficult life is even if one of your fingers is out of action – until you have the injury yourself.'

As the head of the Orthopaedics & Trauma Service at the Lyell McEwin Hospital and head of the Hand & Upper Limb Service at The Queen Elizabeth Hospital between 1995 and 2012, Professor Mah developed the hospitals' orthopaedic surgery capacity to world standard during a period of continual population growth in Adelaide's north.

'From almost no service we expanded gradually, introducing regular outpatient services for a start and later introducing out-of-hours surgery,' he says. 'I think the first joint replacement service was done in 1989 at LMH. That was quite historical.'

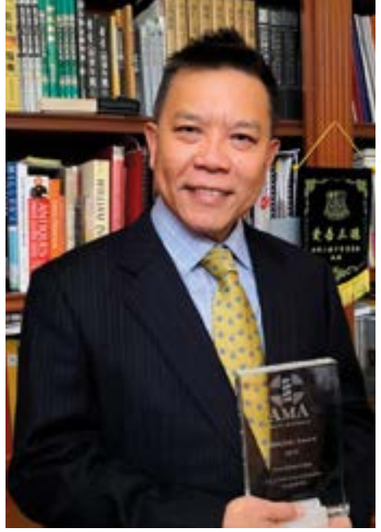
All the time, the focus was on improving the capabilities of the hospital workforce.

'The future of our generation is to train the next generation,' Professor Mah says. 'If I can train them well, not only will they look after us well, but they also make our country better.'

Despite the current backlash against globalisation, he suggests the future of training lies in international networks.

Through the APOA with its 65,000 members, trainees from developing countries have access to world-class training in developed countries while Australian registrars can access the training caseloads they need overseas.

The success of work-safety laws and deindustrialisation in Australia mean registrars are able to travel to countries such as India and Thailand to practise hand trauma techniques and tumour and infection surgeries.



Professor Ted Mah's achievements earned him the 2019 AMA(SA) Award for Outstanding Service to Medicine (above), presented (below) by then President A/Prof William Tam

Meantime, trainees around the world and in rural and remote areas of Australia can access world-class orthopaedic surgery training through real-time webinars.

"It provides equal opportunity for access to education, irrespective of their income and the hospital structure,' Professor Mah says.

'Although COVID-19 is terrible, one good thing out of this is for us to use more and more technology for communication and teaching.

'Much more collaborative work lies ahead. I am certainly humbled and honoured as a recipient of the PSM. I want to use this opportunity as a springboard to invite my colleagues to join in this global effort to open access to fair and equitable orthopaedic education and training.'

Dr Andrew Russell
Councillor

AMA(SA) Council Meeting
March 2020

The March council meeting was a full room including the presence of national President Dr Tony Bartone and Vice-President Dr Chris Zappala.

The initial discussion covered the Women's and Children's Hospital and the need to maintain the current infrastructure while building the new hospital. In addition, Councillors noted, attention is needed to maintain and enhance services so the workforce is at the level required for the population's future care needs.

The recent AMA(SA) Culture and Bullying Summit was discussed. The Summit was viewed as having highlighted cultural problems from top to bottom, and systematic and proven solutions at all levels. A report is expected soon, including a plan for implementation.

Discussion of the COVID-19 pandemic highlighted the need for a national Australian version of a Centre for Communicable Disease Control to support and coordinate a nation-wide response. The analogy was provided that Australia has been 'in a last minute cram for an expected but suddenly imminent exam'. At the time of the meeting Australia had seven identified cases from China, Iran and the Diamond Princess cruise ship. This compared to many more cases of rhinovirus and influenza in the preceding seven days. Strategies such as isolation, social distancing, hand hygiene were being advocated. The need for GPs to be resourced as well as use telemedicine rather than physical visits for high-risk patients with the aid of specific fever clinics was mentioned. It was clear the situation would remain dynamic and significantly affect healthcare workers.

There was a report on the shortage of general practice workforce in rural South Australia with services stretched. Only half of the rural training positions have been filled.

Dr Bartone and Dr Zappala addressed the meeting about a plan to highlight AMA priorities and policy positions of federal AMA to 2030 that is more strategic and proactive than reactive, and would make the AMA more transparent and accountable. It was described as a vision for 'what we want the healthcare system to look like in the future', with a strategic direction of focused advocacy, efficiency, federation and membership. The strategy described a means of achieving better health for all Australians, based on a national health system including access for all, professional independence, sustainability, quality and safety as well as patient autonomy.

GET SOCIAL WITH US!

Twitter: @ChrisMoyAMASA
Instagram: @ama_south_australia
AMA(SA) Doctors Group & AMA(SA) Doctors in Training Committee
Please add #amasamember to your pictures so we can see and share them!

A sharp eye

'Top Gun' technology and reversal of the brain drain points to a bright future for ophthalmology in South Australia.

Dr Edward Greenrod

Trainee ophthalmologists will soon have access to 'Top Gun' surgical simulator technology based at the Flinders Eye Centre, in a boost to the state's training capability.

The new virtual reality surgical simulator – similar to flight simulators – will give South Australia's trainee ophthalmologists the chance to hone their surgical skills before facing real patients, with the aim of reducing trainee complication rates.

It's a welcome innovation at a time when the demand for complex ophthalmic surgery in Australia is rising, says AMA(SA) Councillor and state representative of the Royal Australian and New Zealand College of Ophthalmology (RANZCO), Dr Edward Greenrod.

... 'baby boomers are keen users of modern technology such as smart phones and iPads that can be challenging for people with vision problems' ...

'People's visual demands are increasing into their later years and baby boomers are keen users of modern technology such as smart phones and iPads that can be challenging for people with vision problems,' Dr Greenrod says. 'People require even sharper vision now than they did 20 years ago just to get by in our high-tech world.

'Technological innovations and new surgical techniques also mean we can achieve better results with surgery than we've ever been able to.'

Cataract surgery, for example, had advanced from a procedure where patients were hospitalised for several days to one where they could leave after two to three hours.

Significant advances in treatments for retinal conditions such as those for macular degeneration and diabetic retinopathy had also increased demand for ophthalmology, Dr Greenrod says.

'Until 15 years ago, we just didn't have any effective treatments for these kinds of retinal conditions, whereas today there are a number of biologic therapies that have changed the game completely,' he says.

'This means that the numbers of patients needing either surgery or ongoing treatments for their eyes is rising and, with the added factor of an ageing population, keeping up with the service demand is obviously a challenge.'

Dr Greenrod says that while the number of ophthalmologists had been keeping pace with the growth of the population, there were problems with workforce distribution, especially in regional areas.

And with public hospitals still struggling to find clever ways to adapt to the new electronic records system and dealing with suboptimal staffing levels, space and theatre time at the Royal Adelaide Hospital, in particular, there was still plenty of work and investment required to ensure ophthalmology could meet the growing demand for complex eye treatments, he says.

'While demand for ophthalmology training places in South Australia is high, it remains a tough specialty to get into and having sufficient hospital funding for enough registrar training positions in the SA program remains an ongoing issue,' Dr Greenrod says.

Even so, there's a sense of cultural and technological change building in the profession, particularly around the policy hot potato of bullying and harassment, with the college spearheading a range of programs to reduce bullying of junior doctors and to encourage female ophthalmologists and trainees into more senior roles.

There's also a sense of excitement about growing public awareness of ophthalmology. The state has produced a range of visionaries and world-class achievements – from Australian of the Year Dr James Muecke and his outreach team, to Emeritus Professors Doug Coster and Kerryn Williams and their work on the Australian Corneal Graft Registry.

'South Australia's ophthalmology profession does hit above its weight. There's been a major research in genetic eye disease, inflammatory eye disease, glaucoma and retinal research and surgical management of refractive error,' Dr Greenrod says.

'Adelaide is also world renowned for oculoplastic surgery – surgery for complex diseases of the orbit, the eyelids and tear ducts – which has complemented South Australian expertise in craniofacial surgery and ENT surgery. These teams have often worked collaboratively to create a centre for excellence.'

The hope now is to bring in a new generation to build on that success.

'The medical landscape is incrementally expanding with younger South Australian doctors bringing new skills back from overseas. I'm Adelaide's biggest fan as a place to live and work – it's great and it's tremendous to see junior colleagues making the decision to return to South Australia,' Dr Greenrod says.

'We are also seeing gradual generational change in our health system, which brings space for new ideas and renewed enthusiasm and people who are excited to get involved.

'There are many things to be positive about in ophthalmology and SA Health at the moment, and in light of the challenges we are all facing with the current pandemic, it's great to be able to share a good news story.'

Restoring the balance

Wellbeing SA Chief Executive Lyn Dean explains the role of Wellbeing SA in rebalancing the South Australian health system.

Wellbeing SA Chief Executive Lyn Dean

The establishment of Wellbeing SA as a new agency separate to the Department for Health and Wellbeing is an exciting step towards a significant and renewed focus on prevention in South Australia. Wellbeing SA has a long-term vision to create a balanced health and wellbeing system that supports improved physical, mental and social wellbeing for all South Australians.

South Australians generally experience good health and wellbeing. We enjoy one of the safest and most advanced health systems in the world. However, like the rest of Australia and many other countries, South Australia is faced with significant challenges, with an increasing and changing burden of disease and more demands on the health system that have resulted in the high use of hospital services and rising healthcare costs.

The establishment of Wellbeing SA is a commitment of the State Government in its Better Prevention for a Healthy South Australia and Targeted Health Prevention policies to deliver a renewed focus and action on prevention. Established as an attached office to the Department for Health and Wellbeing, Wellbeing SA will lead changes to ensure a greater focus on prevention; to improve physical, mental and social wellbeing; and to reduce the preventable burden of disease. Using a population health approach, Wellbeing SA will lead community-wide action on the determinants and risk factors of good health and wellbeing and models for care in the community.

Wellbeing SA will work across primary, secondary and tertiary prevention to lead the system change required to support health and wellbeing. This will mean a significant change from a system that focuses on treating people when they become unwell, to one that is based on promoting wellbeing, preventing ill health and supporting people to maintain wellbeing and lead healthier lives.

Wellbeing SA will:

- **Lead** – provide system leadership in prevention, and in the collection and use of data and evidence to inform practice and out of hospital strategies and services
- **Commission** – fund approaches and services for prevention, health promotion, early intervention and hospital avoidance
- **Partner** – work with community and other partners to influence people's health and wellbeing and the coordination of their care
- **Deliver** – implement evidence-based approaches for health promotion and integrated community-based health care
- **Prioritise** – focus on priority settings and priority population groups that are known to experience poorer health outcomes.

Wellbeing SA has three directorates:

- **Prevention and Population Health**
- **Mental Health and Wellbeing** (formally the South Australian Mental Health Commission)
- **Integrated Care Systems**.

With an integrated approach to primary, secondary and tertiary prevention, Wellbeing SA will promote wellbeing and prevent risk factors in well people, identify people who have risk factors or illnesses early so that those conditions can be cured or best managed, and ensure people who have established diseases receive the best care, close to their homes and communities.

Over the past nine months, the ideas and enthusiasm of public health partners and community members have been crucial in designing Wellbeing SA and mapping its future directions, with more than 250 individuals consulted. A Wellbeing SA Community Panel contributed to the development of the Wellbeing SA Strategic Plan and provides advice about community engagement principles. Workshops identified expected outcomes in the first five years and the agency's priority focus areas.

To be released in the coming months, the 'Wellbeing SA Strategic Plan 2020-2025' will outline how the agency will lead the necessary changes to support health and wellbeing. The purpose of the Plan is to establish the first five-year goals for the agency, towards realising an aspirational long-term (20-year) vision. Using the best available data and evidence and considering current policy contexts, the Wellbeing SA Strategic Plan will establish the strategic directions and policy actions for the agency, and the intended outcomes and measures of success.

For more information about Wellbeing SA visit www.sahealth.sa.gov.au/wellbeingsa or email Health.WellbeingSA@sa.gov.au

Taking care of business

AMA Skills Training business graduates are looking forward to putting their new skills into practice.

AMA Skills Training staff attended a graduation ceremony at Watto Purrunna Aboriginal Primary Health Care Service in February to celebrate the accomplishments of eight students who completed the Certificate III in Business Administration.

South Australia's Department for Innovation and Skills supported the training as part of a qualifications project.

'The training was an opportunity to support me in my current administration role in a primary healthcare clinic and to further my skills and knowledge within the workplace,' one of the graduating students said.

AMA Skills Training Manager Michelle Cockshell told the students it was a pleasure to be involved in the program and see the students receive their certificates.

'It was also very rewarding to observe their development through their involvement in this opportunity,' Mrs Cockshell said.

Mrs Cockshell said many practices were finding that providing training and further education for their staff was having benefits for their workplaces.

'Training increases an employee's sense of value, which leads to greater motivation, staff morale and retention, and higher productivity,' she said.

'At AMA Skills Training, we work alongside the AMA(SA). We understand how important practice staff are in identifying and managing the needs of clinicians, nurses, patients and carers, and we are being asked more and more often to develop and tailor programs to ensure staff are ready and able to support their employers' changing requirements.'

Graduating Students and staff from Watto Purrunna Aboriginal Primary Health Care Service and staff from AMA(SA)/AMA Skills Training

Training for your practice

AMA Skills Training provides the opportunity for staff members to enrol in high-quality, nationally recognised training in the following qualifications:

- **HLT57715 Diploma of Practice Management**
- **HLT47315 Certificate IV in Health Administration**
- **BSB31115 Certificate III in Business Administration (Medical).**

Nationally Recognised Training

AMA Skills Training also offer:

- **HLTAID003 Provide first aid**
- **HLTAID001 Provide cardiopulmonary resuscitation.**

Professional development workshops for a practice and its staff can be developed and customised to clinicians' and patients' needs. Popular topics delivered recently include:

- **Providing good quality customer service**
- **Dealing with difficult or challenging behaviour in a healthcare setting**
- **Privacy at the front desk**
- **Dealing with workplace bullying.**

Information is available at www.amaskillstraining.org.au. Enquiries can be directed to Operations Coordinator Gail Hains on 8274 6041 or at ghains@amaskillstraining.org au.

A life of balance

Dr Andrew D'Arcy Sutherland AM
FRACS, MBBS

Orthopaedic surgeon

14 May 1943 - 20 March 2020

Dr Andrew Sutherland

'A man of much substance'

Andrew D'Arcy Sutherland was born in Adelaide in 1943. His father, D'Arcy, was an accomplished cardiothoracic surgeon who pioneered open-heart surgery in Australia and no doubt had strong influence on Andrew (as well as his other son Peter) to pursue careers in surgery and medical leadership. The most revealing example of this effect was Andrew's own election to president of the Royal Australasian College of Surgeons (RACS) in 2007 – the first father/son combination with D'Arcy's term as president 29 years earlier.

Andrew grew up in Adelaide with his siblings Elizabeth and Peter. He excelled at St Peter's College and although offered the opportunity to stay for an extra year in school leadership, he chose to enter university with the lure of a more liberal lifestyle and associated distractions. His desire to enjoy life, while working hard, was obviously cemented early in his career.

Following medical school and some early years as a doctor, Andrew ventured to Canada for five years, and then to the UK, to complete his orthopaedic surgery training. He returned to Australia and was employed at the Royal Adelaide Hospital and the Adelaide Children's Hospital, where his advanced skills were welcomed. He supported Sir Dennis Paterson and dedicated his clinical practice to the care of children, and particularly those with fractures, those suffering the effects of cerebral palsy (then called spasticity) and those with scoliosis. He chaired the Board of the Spastic Centres of South Australia, and was a founding member of the Australian Paediatric Orthopaedic Society and a strong contributor to various societies.

Generations of Australians had their lives improved by Andrew. His expertise in communication and clinical care, and his persistent quest for improvement in outcomes for patients, were witnessed daily. He was a conservative surgeon who made operations seem easy and unhurried, and performed them with finesse.

Andrew was an adept administrator, always willing to hear various opinions and statesmanlike in providing formal advice even when faced with difficult decisions. Andrew was an examiner in orthopaedic surgery for RACS and Chief Examiner for Australia. He dedicated himself to these honorary activities with passion, innovation and achievement; he was never passive on committees and always strongly voiced for improvement and action. For 10 years he was head of orthopaedic surgery at the Women's and Children's Hospital and then chief of surgery. He worked in close collaboration with the nursing staff for whom he was the strongest medical advocate because of their importance in healing children.

It is the activities outside one's formal career that are usually the most revealing and, with Andrew, there is an extensive list. From an early age he was drawn to the sea and sailed lightweight sharpies at Glenelg Sailing Club with his brother Peter and various crew. These large dinghys were sailed by only the toughest and bravest, and set the scene for many later adventures including three Sydney to Hobart Yacht Races as navigator on board David Urry's 'War Games'. He was in his element in rough conditions and regaled us with stories of brave men on the foredeck whom he admired for their resilience. He rounded out his nautical interest with appointment to the Board of the National Maritime Museum in Sydney.

Andrew married Sibby in 1998 and together they ventured across the world, enjoying invitations to visit from many friends. I have vivid memories of travel across India with Andrew and Sibby – he was determined to witness the true India firsthand and insisted in choosing second-class sleepers. Sibby and Andrew were so wonderful together.

In 2010 his contributions for service to medicine as an orthopaedic surgeon, an innovator in the field of surgical education and assessment, and as a mentor of young doctors was recognised with the award of an Order of Australia (AM).

Light planes and a pilot's licence supplemented his navigation penchant, supplemented by a surprise birthday present of syndicate ownership in a Mooney aircraft from Sibby. This set the scene for adventures across Australia with long flights to places such as Perth and Cairns as well as many other expeditions. He was lucky to cheat disaster when both fuel pumps failed over Spencer Gulf: with the engine out of action, he calmly instructed Sibby, colleague John Stephen and John's wife Christina to don their lifejackets; called Mayday; and then gently glide-turned 180 degrees before safely landing the plane in a farmer's wheat-field on Eyre Peninsula (with no human injuries). The farmer welcomed the surprise arrival of surgeon Andrew who had recently operated on his own daughter!

Tributes from Australian and international friends and colleagues have been prolific. So many have described his true warm friendship, stimulating conversations, erudite nature, and constant desire to do good things. Andrew is remembered as the quintessential gentleman.

Some messages of condolence are worth repeating: 'Today we have lost one of our finest', as well as a most telling tribute from one of his closest friends, 'A man of much substance who knew how to get the most out of life'.

Peter Cundy FRACS

In his debt

Dr John Stanley Flett AM CStJ
B.Sc. Uni. Adel., MBBS Uni. Adel. 1951, FRACGP 1970.

19 December 1921 - 21 February 2020

Dr John Flett was known for proclaiming 'This is what we should now do!'

'This is what we should now do!'

John Flett was born in Norwood, South Australia, and grew up in Magill. As for many families of the era, money was tight and he was often hungry as a child. One of his brothers died at the age of six from bacterial pneumonia, now treatable. John nursed the rest of his family through an outbreak of diphtheria by boiling their sheets. By 11-12 years of age, he was recognised in the neighborhood as someone who could fix health problems; once he put a boy's detached nose back onto his face with a peg. This formed the background for John's eventual career. He went to Adelaide Technical High School, excelling in art among many subjects, and enrolled in science at the University of Adelaide at 16 years of age.

At 20 John graduated with a B.Sc. In 1940, he enlisted into the RAAF. This enabled him to enter the new field of radar. He was fast-tracked to be a Commanding Officer and was in Sydney when the Japanese submarines entered the harbor. While posted to Cape Naturaliste near Busselton in WA, he met his future wife Hilda. Later, as the war ended, he resisted invitations to remain with the RAAF and entered the Medical course in March 1946. He married Hilda in August 1946 in Busselton and moved to Adelaide to continue his medical studies, graduating in 1951, a year after the birth of their son Peter.

John moved to Kadina at the invitation of Dr Lew Thyer, who was looking for a colleague in his general practice. He had a typical rural general practice of that era with consulting, surgery and anesthetics. He also had a busy obstetric practice delivering 90 to 100 babies a year in the smaller Kadina community hospital and the larger Wallaroo hospital.

John's surgical skills were well recognised in Adelaide, and surgeons in Adelaide referred patients back to him to operate.

I recall both as a high school student and as a medical student observing my father's medical practice. His consulting rooms 'nurse' kept a book of accounts with fees made by some sort of scale. Farmers often had it tough on the land and would pay when the season was good. It was not unusual for me to hear a knock at the back door and there would be someone I'd never heard of standing there with a leg of lamb or a dozen garfish or a large pumpkin for 'the Doc'.

Sometimes, when there was no local vet available, the farmers would bring in their dogs with broken legs. My father would get me to anaesthetise them with a clean rag and chloroform while he set their legs with plaster of Paris in our garage.

As public health officer for the Kadina Council, John was responsible for introducing a common effluent system in Kadina after numerous outbreaks of gastroenteritis. He also led and established many community projects and services, including Kadina's first kindergarten and a new golf course. He played the cornet with the Kadina, Wallaroo and Moonta Band and was its patron until his death. John was a Rotarian and keen bowler. He took a great interest in the older citizens' community and helped establish the Wontama nursing home in Kadina.

John was an active Christian, with ability to develop interdenominational friendships with various ministers.

John had two pediatric patients who died suddenly a year apart from what was to be diagnosed as amoebic meningitis. I recall Dr Rodney Carter, Director of Pathology at the Adelaide Children's Hospital (ACH) talking with my father about the clinical history, especially in relation to the second child aged 10, and asking him to look at the organism under a microscope in Adelaide. It was John who interviewed observers and discovered that that child had been splashing water from a trough onto her face in the hot weather. He proposed that the suspected organism (later named by Dr Carter as 'Naegleria Fowleri' after the former Director of Histopathology at the ACH) had entered the nose before infecting the brain. Within a matter of months, the pipelines and swimming pools were compulsorily chlorinated. Several cases also occurred in Port Augusta, where two GPs had been convinced that the water was responsible.

John studied, sat and passed the RACGP examinations in 1970. I recall as a medical student reading his long case: it was about his son and my brother Rodney, who died at the age of 16 years 9 months from a rare testicular cancer after a lifetime of struggle with severe epilepsy and secondary intellectual disability. John never really got over the grief of Rodney not being able to learn like 'normal' children, let alone the loss of his life at such a young age. In retirement, John would take up art and painting, which he achieved to a high enough standard to have exhibitions raise about $100,000 for children's cancer charities aligned to Rodney's illness.

John's involvement with St John Ambulance began as a Corps Surgeon of the St John Yorke Peninsula Corps in 1952, lecturing to volunteers every Thursday night for 40 years. He persuaded the local Council to give land and then establish an ambulance station. He was appointed Officer Brother in 1982 and the highest appointment - St John of Commander (CStJ) - in 1992.

John was in full time general practice in Kadina for 33 years, before going part-time at the age of 63 years. He completed his commitment to the region by campaigning for a new hospital on Northern Yorke Peninsula and then chairing the hospital's board and building committee.

Dr John Flett is awarded life membership of the Royal Australian College of General Practitioners by then-President Dr Vasantha Preetham in 2005

John Flett was a South Australian nomination for Australian of the Year in 2004 and in 2005. In 2005 he was awarded Member of the Order of Australia (AM) for 'services to the community through fundraising for charitable organizations, executive roles with St John Ambulance and involvement in a range of organizations in the Yorke Peninsula area'.

John died on 21 February 2020, two months after his 99th birthday. He is survived by his son Peter, daughter-in-law Louise, four grandsons and six great grandchildren.

This is an extract from the eulogy read at Dr Flett's funeral by his son Dr Peter Flett FRACP, FAFRM (Paediatric Medicine, Rehabilitation Medicine).

WE'RE HERE FOR YOU

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

As AMA(SA) staff are working without our business phones, it may be necessary to leave a message. If you call in office hours, someone will return your call within 24 hours.

All calls and emails are logged and acted upon. Your views and concerns are passed through to the President, CEO or AMA(SA) Council, and some issues are forwarded to the AMA's Federal office.

Thank you for your understanding.

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

Phone: 8361 0100

STAY CONNECTED

The AMA(SA) is working closely with SA Health and other organisations to communicate the latest information to doctors and health practitioners across South Australia.

We are working with SA Health, the Royal Australian College of General Practitioners, SA Pathology and other partners to stage regular webinars to update GPs and their practices, and President Dr Chris Moy is also sharing updates via webinars.

To learn about webinars and other COVID-19 updates from the AMA(SA), please check your inbox for Informz newsletters and follow us on Twitter and Instagram.

GALA DINNER AND AMA(SA) ANNUAL AWARDS

Each year, the AMA(SA) presents two awards at the Gala Dinner: the AMA(SA) Award for outstanding service in medicine and the AMA(SA) Medical Educator Award.

The 2020 Gala Dinner has been cancelled due to COVID-19, and the awards will not be presented this year.

AMA(SA) ANNUAL GENERAL MEETING AND MAY COUNCIL MEETING

The Annual General Meeting (AGM) of the AMA(SA) has been postponed and will not be held at AMA House as previously scheduled on 7 May 2020.

The AMA(SA) Executive Board has decided that an online format is not suitable for an AGM, during which all participating members must be able to provide questions and comments and have their involvement recorded. The postponement is in line with the South Australian Government's Consumer and Business Services advice.

We will inform members of the revised date as soon as possible. Please note also that due to COVID-19 restrictions, the May meeting of the AMA(SA) Council, also scheduled for 7 May 2020, has been cancelled. Please contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au if you have any questions.

AMA(SA) COUNCIL MEMBERSHIP

Reference to the AMA(SA) Constitution has confirmed that appointments to our Council extend from one AGM to the next, so that the terms of existing members and the President and Vice-President will continue until the AGM can be re-scheduled.

If you have a question about nominating, please contact the Chief Executive Officer, Dr Samantha Mead, on 8361 0109 or at CEO@ amasa.org.au.

DO WE HAVE YOUR CORRECT DETAILS?

If your contact details, place of employment or membership category has changed – for example, if you're no longer a student or you've recently retired – please let us know so we can update your details.

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

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

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MEMBER BENEFITS FROM HOOD SWEENEY

Our preferred accounting and financial planning provider Hood Sweeney has extensive expertise in the health and medical industries, and is passionate about supporting AMA(SA) members.

For information about the generous discounts and benefits available to you as an AMA(SA) member, or to speak with a specialist adviser, please phone 1300 764 200 or email amasa@hoodsweeney.com.au

NOTICES

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

Richard Hamilton continues to practise Plastic and Reconstructive surgery at Hamilton House, 470 Goodwood Road Cumberland Park with special interests in skin cancer excision and reconstruction, hand surgery and general plastic surgery. Convenient free car parking is available.

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

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

www.hamiltonhouse.com.au

#COVID19Aus
#FlattenTheCurve

Thank you to the doctors, healthcare workers and everyone putting their lives at risk to keep Australians safe.

AMA
SOUTH AUSTRALIA

www.amasa.org.au

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