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We have recently installed Bone Density scanners at our Port Augusta and Gawler Heath Service clinics.

Patients and referrers from the Spencer Gulf region, Northern Adelaide region and Barossa region can access our new Bone Density service.

This investment builds on our commitment to deliver high-quality, accessible medical imaging services to regional communities.

Our Southern Specialist Centre and Burnside clinics upgraded their already existing Bone Density services, completing the Bone Density fleet upgrade for 2020.

Upgraded Magnet

MRI at our Modbury Clinic

We are now offering additional rebated and non-rebated MRI services at our Modbury clinic, with the installation of our new licenced Siemens Aera 1.5T scanner.

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Head | Cervical spine | Knee*

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MRI at our Gawler Clinic

We will soon be installing MRI at our Gawler clinic, located within the Gawler Health Service.

> **This represents a further substantial investment in our range of services offered in Gawler.**

The service will be of significant benefit to local patients and referrers, and will service both inpatients and outpatients throughout the Gawler and Barossa regions, and other areas in regional South Australia.

*Where clinically indicated

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As the world confronts the health, social, economic and environmental impacts of COVID-19, South Australia's universities have rushed to offer their expertise in studies ranging from vaccine development to using celebrities in health promotion. For this issue, *medicSA* asked Flinders University, the University of Adelaide, UniSA and SAHMRI to summarise their pandemic research and any early outcomes.

Pictured here are Dr Harriet Whiley and Dr Kirstin Ross testing masks at Flinders University.

Editor's letter

Dr Philip Harding

This issue of *medicSA* is the third that you, as an AMA (SA) member or subscriber, will have received in paperless format, delivered simply by following a link in an email or visiting our website. So, welcome – in your role as a consumer – to the brave new world of online publishing! This major change has been one not taken lightly by AMA(SA) and in particular its editorial committee and key staff members. It has been the subject of much deliberation for well over a year. As an editorial committee we were very much aware that we were following an overall trend in the publishing industry, as well as to some extent in the AMA itself and particularly some of its state branches. But the decision to go ahead was obviously accelerated by the pandemic and the implications it has had on infection spread.

In considering the move we were very much aware that there would be those among our readers who preferred the concept of a 'real' magazine with pages to turn, but so far there has been minimal complaint. It does seem to us that acceptance of the new format has been widespread, even enthusiastic, in a high proportion of our subscription list. There is no reason for us to have any negative feelings about the decision to move in this direction.

Certainly it is my own feeling that *medicSA* continues, in this new world, to provide a comprehensive spread of relevant, important and hopefully at times entertaining medical news in a way that effectively assists our mission: to communicate such matters to our membership and the profession at large. Of course, if you should feel that there is any way in which we are not achieving this as well as we might, please don't hesitate to provide some feedback by emailing editor@amasa.org.au.

On a personal note, I should add that I'm aware that many of my friends and colleagues are quite well-informed about the health problems I have experienced in recent months – particularly perhaps since the 'brain tumour masquerading' article published in the August edition of *medicSA*. Be sure that I have greatly appreciated the messages of concern and support received as a result.

Please continue to stay safe.

Colleagues remember surgeon and friend

Respected plastic surgeon Dr Richard Watson has been remembered as a person of great integrity, as a doctor and as a family member and friend.

The son of a Yorke Peninsula GP, the young Richard Watson studied medicine at the University of Adelaide and, in 1956, began a lifelong association with St Mark's College. His fascination with flying led him to train as a pilot.

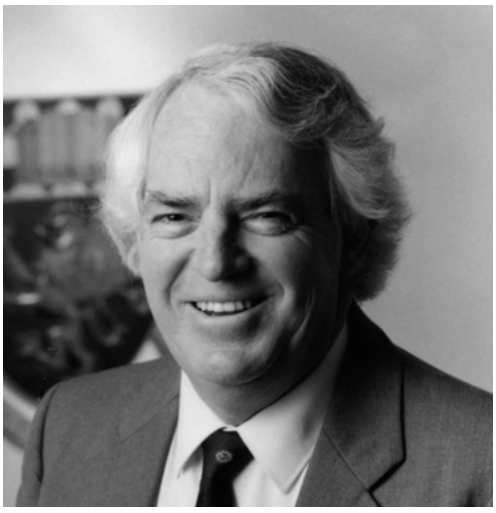
Moving to the UK in 1963, he joined the British army as a medical officer. He was made a captain and trained as a paratrooper and would later become a patron of the British Airborne Forces Association of South Australia, a position he held until his death.

He lectured in anatomy at Guy's Hospital in London from 1964 to 1966, and worked as a plastic surgeon in Bristol and Glasgow from 1967 to 1971. He became a Fellow of the Royal College of Surgeons of England in 1968.

Dr Watson returned to Adelaide in 1972 to practise plastic surgery at the Queen Elizabeth Hospital, and became a Fellow of the Royal Australasian College of Surgeons that year. He specialised in reconstructive hand surgery, repairing factory workers' injuries, and also lectured in surgery at the University of Adelaide.

In the 1980s, Dr Watson twice served as ship's surgeon on supply ships to the Antarctic, recording the bird logs on both expeditions.

He helped establish and led the plastic and reconstructive surgery unit at the QEH from 1989. He was a founding member of the Australian Hand Surgery Society.



Dr Richard Watson

In 1989, he returned to study, topping the state in Year 12 classical studies while still working full-time. This led to a Master of Philosophy, majoring in medical history, from Oxford University in 1995.

Dr Watson died in Adelaide on 14 June, aged 83.

Quietened consumers

The withdrawal of funding for South Australia's peak consumer 'voice' will have serious ramifications for patients' health, writes its former Acting Chair Paul Laris.

Health Consumers Alliance of South Australia (HCASA) has been the recognised peak voice for health consumers in South Australia for almost 20 years. As expert partners, HCASA has worked with consumers, health services and government to improve health outcomes. HCASA lost its State Government funding in June 2019 after 19 years of continuous service. The HCASA's annual budget allocation from the SA Government was $500,000, around 0.008 per cent or one twelve thousandth of the SA Health budget for the current year. With HCASA'S closure in September 2020, South Australia will be out of step with other states, all of which have government funded, independent and systemic peak health consumer organisations.

The Minister's position is that the decentralisation of governance to the Local Health Networks (LHNs) means funding to HCASA is no longer needed. The underlying premise in this decision is that with the implementation of consumer engagement strategies at a local level, an independent systemic advocacy agency is no longer required. The flaw in this thinking is that it considers that 'consumer engagement' and 'advocacy' are one and the same. This fails to recognise that while consumer engagement strategies provide effective tools for consumer participation, systemic health advocacy provides evidence-based consumer representation in health policy and identifies system-wide problems, issues and risks that impact the health and wellbeing of health consumers.

Health advocacy is central to providing better opportunities for people:

- to access the health care they need and want
- to have greater access and equity for those who experience health disadvantage
- to demand and receive their health rights
- to improve their lives through improving their health.

HCASA's mandate has been to advocate for health rights of all South Australians, to influence positive change in the SA health system and better respond to the needs of the community. It has done this by building the capacity of health services and its workforce to meaningfully engage with consumers to inform health service design and decision-making. HCASA has built the voice of consumers and communities, particularly those living with health disadvantage, while supporting the capacity of the health system to listen and respond.

Who, if anyone, will have the responsibility for this in the future? In the absence of systemic advocacy this additional oversight will be missed, with potentially catastrophic outcomes for individuals and collective groups. We are not strangers to such events. Issues relating to Oakden, medical mesh and chemotherapy under-dosing are all in South Australia's recent history. The need for independent health advocacy has never been greater.

While the health consumer advocacy peak bodies in all other states and the national health consumer body receive recurrent government funding, it is becoming increasing clear that long-term partnerships between government and its 'critical friends' can no longer be relied upon for secure and sustained funding. It will always be risky to bite the hand that feeds you - or even to growl a little. Nevertheless, core government funding, coupled with some guarantee of independence, is essential to ensure a health consumer advocacy model that can achieve its core mission with legitimacy.

With the loss of a critical friend, the SA Government and SA Health will be left open to scrutiny for their lack of transparency and accountability and their failure to ensure South Australians have access to appropriate and independent advocacy when something goes wrong with their health care.

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President's report

Dr Chris Moy

The leaders among us

Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others. — Jack Welch

A few weeks ago, I returned home to be given the news that my daughter Natasha had been elected President of the Adelaide University Engineering Society (AUES), sister organisation to the Adelaide Medical Students' Society of which I was a member 30 years ago.

Apart from feeling old and concerned about how two presidents would be able to coexist under one roof, it did make me reflect on what leadership really means and how my perception of it has changed in my time as AMA South Australia President.

Having attempted to avoid leadership roles for much of my life, and believing that it required an unattainable level of bravery and extroversion, I now have such a different view of leadership which is very much in line with the sentiments expressed by Jack Welch.

Having had great leadership mentors in Drs Peter Ford, Patricia Montanaro, Janice Fletcher and William Tam, my own time as president has been marked by a joy in seeing new leaders arising from all levels of AMA(SA).

All AMA(SA) Council members have stood tall during the extraordinary COVID-19 pandemic. Dr Bridget Sawyer has led the newly re-formed AMA(SA) Committee of General Practice to an already vibrant level of activity. Drs Hannah Szewczyk, Jemma Wohling and Samantha Jolly have led an incredible revitalisation of the AMA(SA) Doctors in Training Committee and forged the way ahead, particularly on the matter of improving culture and reducing bullying in SA Health workplaces. And one of the unexpected sources of joy for me has been supporting the incredible talent in leadership that I have seen at the Flinders Medical Students' Society (FMSS) — such as Matilda Smale and the now Drs Mekha John, Riche Mohan and Jarrod Hulme-Jones — and the Adelaide Medical Students' Society (AMSS) — in Jade Pisaniello, Patrick Kennewell, Teham Ahmad, Jack Rumbelow and Dr Tom Gransbury — in navigating huge challenges relating to major directional changes of courses at both universities topped by COVID-19 threats in 2020.

What has become clear to me in working and growing as a leader alongside my colleagues, is that leadership is less about telling people what to do and directing them than listening and working with others to face and solve problems. Maybe this is less sexy and glorious than the traditional view of leadership, but it is certainly less lonely and a lot more satisfying to overcome and solve challenges shoulder-to-shoulder with colleagues and friends.

And perhaps my experiences with the burgeoning AMA(SA) leaders have been a microcosm of the role of the profession and the AMA in 2020. Faced with a once-in-a-generation threat, all our members have solved problems for the benefit of the community. And maybe Jack Welch's view about leadership being about seeing growth in others will not only ring true of the next generation of doctors, but also resonate with the community in reinforcing the value of leadership and service.

… leadership is less about telling people what to do and directing them than listening and working with others to face and solve problems …

Public hospital performance continues to slide

The AMA's annual examination of the country's public hospitals shows continuing problems for Australians seeking access to and treatment in the public system.

The performance of Australia's public hospitals has recorded a continuous decline since 2013-14, pointing to the need for greater investment and measures to reduce the decline of private health cover, says the AMA.

The AMA's 2020 Public Hospital Report Card, based on data from the Australian Institute of Health and Welfare, shows access to public hospitals declined in many jurisdictions and waiting times increased – including in South Australia.

Nationally, more patients were added to elective surgery waiting lists in 2018-19 than were admitted for their elective surgeries. The national median waiting time for elective surgery was the worst performance since 2001-02.

More than 8.3 million patients presented to public hospital emergency for treatment and more than 3 million emergency patients required urgent care, but only 63 per cent were treated on time, the report card found.

Between 2013-14 and 2018-19, the number of emergency patients who required a subsequent admission also increased by 5 per cent on average, each year. The increase is 1.73 times the rate of growth in total emergency presentations each year, and 3.5 times the rate of population growth.

Given that the report card is based on 2018-19 data, the situation is likely to have further deteriorated following pressure on the public health system caused by COVID-19.

The AMA's Federal President Dr Omar Khorshid has urged the government to:

- provide adequate funding to cover the predicted increase in demand for public hospital services
- recognise the impact of COVID-19 on state government budgets and the limits on their ability to fund growth in public hospital services
- address the ongoing fall in private health insurance rates and preserve the capacity of the public hospital system to provide care to those who need it most
- support general practice to deliver high-quality primary and preventive care to prevent avoidable hospital admissions.

In South Australia, AMA(SA) President Dr Chris Moy said the Public Hospital Report Card showed South Australia's public hospitals treated less than half of all urgent emergency patients in the clinically recommended 30-minute timeframe.

The report card notes that one of the best measures of public hospital capacity is to compare the number of available beds to the size of the population and on that measure, South Australia experienced the greatest decline in the country (down five beds per 1,000 population).

At a national level 2017-18, the number of available beds per 1,000 resident population was 2.51, a reduction from the previous year (2016-17) when there were 2.55 beds per 1,000 population.

'South Australia has been a perennial and disappointing laggard over the last decade in the areas of time taken to be seen in emergency departments and waiting times for elective surgery,' Dr Moy said.

'Response times in emergency departments are deteriorating with the only glimmer of hope being some improvements in elective surgery waiting lists – despite South Australia having the highest per-capita public hospital funding.

'These declines have occurred during periods of great change in the SA Health system with a new major hospital being built, the roll out of a new a new electronic record system, an attempt at sweeping change in the controversial "Transforming Health" initiative and despite South Australia having the highest per capita public hospital funding.'

In his overview of the state figures published within the Report Card, Dr Moy asked for a greater focus on people and the services they need, rather than on building and construction.

'One hopes that the new State Government which was handed responsibility for health during the latest figures will change the focus away from buildings and big-ticket initiatives, to the 'on the ground' needs of patients, doctors and other health workers – so that South Australia's figures can improve,' Dr Moy wrote.

South Australia did report an improvement in the median wait time for elective surgery (all categories) while the waiting time for category 2 elective surgery patients was static. South Australia also noted an increase in real commonwealth and state funding of state hospitals per person.

Of further concern to the AMA is that the focus on COVID-19 has meant patient participation in cancer screening, general practice check-ups and diagnostic testing has declined and a backlog of patients needing urgent access to treatment is likely. The AMA warns that public hospitals do not have the capacity needed to rapidly expand the volume of public hospital care.

The AMA also warns that the balance between public and private hospitals is increasingly precarious, creating further pressure on public hospitals.

Pandemic reinforces need for private health reform

The AMA's annual review of private health insurance finds differences in funds' policies and benefits continue to confuse consumers

The AMA has found Australia's private health system is under real stress with financial pressure prompting many younger people to abandon their cover and the system weighed down by older people with complex health problems.

In releasing the *AMA Private Health Insurance Report Card 2020*, AMA President Dr Omar Khorshid said private health fund membership was continuing to decline and was likely to come under further pressure from the COVID-19 pandemic.

Dr Khorshid said scheduled premium rises were likely to lead to even more people giving up their insurance at a time when the system could ill afford it.

'We have experienced five years of continuous decline in the proportion of Australians with hospital insurance,' he said. 'This is only likely to get worse as a result of the global pandemic, as people face unemployment or underemployment, and the economy is in recession.

'Worse than this, the people who are dropping their insurance are young, healthy people, while people over 65 years are taking it up in increasing numbers.

'The greater the mix of older Australians in the insured pool, the greater the claims, and the greater the premium rises. As premiums increase, they price out of the market those who are least able to afford it, including large numbers of younger Australians, and families.

'Unless the drift away from private health insurance is stopped, we will see even more pressure on an already stressed public hospital system.'

The Federal Government's recent reforms to simplify the private health insurance introduced Gold, Silver, Bronze, and Basic categories of cover. But the report card found that the changes had failed to stem the flow of members.

The 2020 Report Card provides the latest comparison of the proportion of hospital and medical costs covered by each fund, and examples of common procedures where insurers pay different levels of benefits.

In his foreword, Dr Khorshid said the differences 'can have a significant impact in the support a patient might experience from their health fund when they undergo treatment' – and that the AMA highlights these features to help consumers understand their likelihood of facing out-of-pocket costs across different insurance providers and products.

The intention, he suggested, was to encourage people to review their policies to ensure they met their individual needs.

The report card notes that the system's complexity is another barrier for members, with many failing to understand what their money buys.

It points to three aspects of private health insurance for hospital treatment that it identifies as being commonly misunderstood:

- not all private health insurance policies cover every medical treatment
- insurers can change what is covered by a purchased policy, but they must tell patients
- patients will sometimes have out-of-pocket costs even when their policy covers the medical treatment they need.

The AMA has called for comprehensive reforms to premium rebates, lifetime health cover loadings, the Medicare surcharge levy, youth discounts, long-term incentives for people to maintain their cover, and a minimum level of benefits for patients.

'Private health insurance is one of the single largest and most complex purchases the Australian households will make each year,' Dr Khorshid said.

'As people's incomes have been hit by the impact of the COVID-19 pandemic, this choice is even harder for many Australians.

'Achieving value for money must be the Government's top priority when it comes to private health insurance.'

The AMA noted Australian Prudential Regulation Authority figures which showed that 97.7 per cent of medical services in Australia were provided at either no-gap or known-gap in the June 2020 quarter, up 3 per cent on the same quarter in 2019.

Doctors' fees accounted for only 13.1 per cent of out-of-pocket expenditure for patients – in 2017-18, patients spent $9.4 billion (30.8 per cent) on over-the-counter medications, vitamins, and health-related products, and only $4 billion on medical services.

In the latest quarter, insurers paid $3,314 million in hospital treatment benefits, comprising:

- medical services - $473 million (14.3 per cent)
- prostheses items - $444 million (13.4 per cent)
- hospital services such as accommodation and nursing - $2,397 million (72.3 per cent).

The Report Card demystifies the complexities of private health insurance – explaining how out-of-pocket costs occur, how choosing an insurance policy based on the cost of premiums can result in higher expenses later, and how benefits and gaps vary across insurers, but also on a state-by-state basis, even with the same insurer.

It compares the proportion of hospital and medical costs covered by each fund and provides examples of common procedures where insurers pay different levels of benefits.

The *AMA Private Health Insurance Report Card 2020* is available at https://ama.com.au/article/ama-private-health-insurance-report-card-2020

Pandemic magnifies fissures in aged care

At the height of the COVID-19 pandemic, the CEO of an aged care home observed she was receiving long lists of often conflicting daily directives from 16 different federal and state health and aged care organisations without anyone from these agencies actually doing anything to help.

At another facility that AMA(SA) President Chris Moy visited, a nurse said that despite being told that all staff must wear masks, the facility had only two packets of masks.

'Everybody is good at telling aged care facilities what to do, but not very good at providing the resources on the ground that are required – that's the lesson of COVID,' Dr Moy says.

Dr Moy is a GP who regularly visits aged care facilities and patients, and has long advocated for the rights of and better conditions for ageing Australians within and outside residential care. He says the rapid spread of COVID-19 through aged care facilities had exposed the deep-seated problems caused by a disconnect between accountability and funding along state and federal lines, as well as the chronic underfunding of aged care facilities and doctor services to aged care.

'We need to look at that and improve the funding but make sure the line of funding and the line of clinical responsibility are far more aligned to the interests of the residents,' he says.

'The biggest problem in aged care is that it is caught between silos ... Aged care facilities were caught in every way; they get funding from federal government but work within the context of state health system. Also, the health services are provided by general practitioners (GPs) who are funded by a separate stream from the federal government through Medicare.

'When you have funding coming from different sources and there is a mismatch with the lines of clinical responsibility – that's been totally exposed during COVID. That's why everybody has been pointing the finger, but nobody quite knows how to start to fix it.'

Dr Moy says the AMA has made many submissions to government about inadequate funding for GP and non-GP specialists to visit aged care facilities, as well as poor integration between aged care facility systems and those of doctors – but that the arguments have 'fallen on deaf ears'.

The lack of funding for aged care had long been a problem, resulting in poor outcomes for residents, he says. Then there is the matter of access to medical services.

'Aged care funding for GPs has been really pretty awful for a long time now and a lot of GPs just won't visit aged care facilities,' Dr Moy says.

'Because GPs are funded by one mechanism (Medicare), aged care facilities by another (federal) and hospitals by another one still (state), there is little incentive for these silos to work together and in fact a disincentive to do so should residents deteriorate medically.

> ***... What facilities need is expert infection control advice to go in there and work with them ...***

'If the GP can't come in, or the facility can't get a GP to visit a deteriorating patient, the facility will focus on its medico-legal concerns and may transfer the patient to a hospital even if this is against the patient's wishes – leading to an unwanted or unnecessary admission.

'If these silos did not exist, the patient's GP could have attended and treated the patient and worked together with the facility's staff for the good of the patient to keep them in their home. But instead ends up in the worst-case scenario, where the patient is in hospital, regardless of their wishes.'

Dr Moy says the AMA has repeatedly highlighted the need for greater aged care funding – and the need for transparency about where the money is spent. Pressure on unit costs had led to a tick-a-box approach to meeting standards, Dr Moy says.

'I've actually worked in aged care facilities since 1995 and I've seen that difference ... when I first started it was much more compassionate and about looking after the patient he says. Now it's become less and less about the patient as a human and more and more about ticking the boxes to meet accreditation standards and claim incremental funding increases.

'The best organisations are good at ticking the boxes so that when the accreditors visit they look absolutely fine. But the question must be: 'what about the person in front of them?'.

He says the focus on disembedded compliance had been exposed during the pandemic. For example, some facilities told to collect contact details of all visitors had merely provided a book with a pen attached or an iPad, with all visitors using the same pen or keyboard – ideal for spreading infection.

'Yes, they ticked the boxes, but did they get genuinely good infection control advice? It's all very well to say that carers have to go into care for one patient each and be masked up, but what about the subsequent mingling of food trays that come out of each room? Do they come into the communal area when they are potentially infectious?

'Management of food trays, waste and clothing are all things that have not been dealt with in the past and they have to be considered now. What facilities need is expert infection control advice to go in there and work with them,' Dr Moy says.

'Certainly, we need accountability but there is a need to rebalance onto a focus on the resident as a human being, and what they really want and need in the care they receive. You can go overboard in ticking the boxes because all you are really doing is ripping the heart of what it is really all about – and that's the person.'

He pointed to the need for a stronger focus on patient wishes and the use of Advance Care Directives, including the documentation of any chemical restraints.

'A big issue now is the use of chemical restraints,' Dr Moy says. 'There is no doubt that there has been an overuse of them, and I think culturally we have to get away from just using medications to solve problems and ensure that

it is the last resort and in line with patient's wishes.

'But one of the things I've been involved with is making sure that the use of chemical restraints is not just determined by a blind focus solely on safety.

'The argument [against medication] is that, for people who have severe dementia, some medications can make them drowsy, and increase the risk of falls, strokes and heart attacks. That sounds reasonable but sometimes someone with severe dementia ends up doing things that are disinhibited and really embarrassing, such as pushing over staff, shouting and swearing – or worse.

'The wishes and values of those patients should also be taken into account alongside considerations of safety.

'In an end-of-life situation with a person with severe dementia who is acting out in a way which goes against their previous values, the question is whether avoiding stroke or a heart attack is a more important priority. My personal values would be such I'd rather be medicated and drowsy, and accept any risk of side effects, than be remembered for unknowingly acting inappropriately at the end of my life.

'The debate is focused only on risk reduction but I'm advocating that we must also make decisions with the patient's values and wishes in mind.'

The troubles in aged care were unlikely to be solved by a trend towards older people remaining at home – without significant consultation with GPs and how they will be funded and supported to provide medical care for these patients,' Dr Moy says.

'It is much, much harder for GPs to go from home to home and there is a long-standing problem with funding GPs to do home visits because it is really not even close to adequate. So, for doctors to go out there, we need to develop a realistic funding model.

'The push for home care can't be done in isolation because we will end up in the same place. You can say "great, they can stay home", but if you can't get GPs to go out and provide medical services that's going to undermine the whole thing.

'That's possibly where telehealth really does matter because it could be a crucial part of home care.'

Transparency urged in aged settings

The aged care system needs to be re-designed focusing on what the resident wants – and with financial transparency, says AMA(SA) president Dr Chris Moy.

Dr Moy says that too often in recent decades, he has seen residents of aged-care facilities promised much with little delivered in terms of staff-to-patient ratios, food and services as the focus has shifted towards a financial and compliance lens.

As he visited regular patients Pastor Thomas and Una Reuther in their suburban aged-care residence, Dr Moy repeated the AMA's call for transparency in where facilities spend their money.

'Certainly, there should be adequate funding of aged care but some of that is about transparency and some of it is clinical provision of care and that involves doctors and other providers,' Dr Moy says.

Facilities that charge residents for chef-cooked meals but serve food that is 'nothing of the sort' are essentially defrauding them, he says.

The AMA has issued a range of position statements, submissions and media releases over the past few months calling for urgent action to improve the conditions for residents – particularly in the light of extensive COVID-19 outbreaks in aged care facilities.

'One of the things that became obvious throughout the pandemic is risk associated with the movement of staff across facilities because they are paid poorly,' Dr Moy says. 'There needs to be more consideration given to aged-care design issues and perhaps workflow issues.'

In a joint release, the AMA and the Nursing and Midwifery Federation of Australia said the aged care sector was particularly vulnerable in the pandemic and staff and residents faced unacceptable risks of contracting the virus. It called for:

- the immediate establishment of the nationally agreed Aged Care Health Emergency Response Operations Centres (ACERC) to help prevent outbreaks
- mandated minimum staff-to-resident ratios and a mandated skill mix, with registered nurse presence 24/7
- adequate access to PPE, training in infection control, and reviewing infection control procedures
- national paid pandemic leave arrangements
- increased funding for home care packages
- transparency and accountability in aged care provider spending.

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Being well in a lockdown

International researchers including in South Australia are investigating how the pandemic and associated lifestyle restrictions are affecting people's mental health and wellbeing.

Matthew Iasiello is a researcher in SAHMRI's Wellbeing and Resilience Centre. The centre was created in the midst of a broad global conversation of positive psychology, including the visit to South Australia of the international advocate, psychologist and author Dr Martin Seligman in 2012. Dr Seligman promoted the importance of positive psychology and resilience; since then, Mr Iasiello says, and as psychology has moved on from its traditional focus on treating mental health, the centre has increasingly targeted the promotion of 'the positive states of mental health and wellbeing'.

'Healthcare is increasingly moving to health promotion and prevention measures, and we're doing that in the psychological space,' he says.

Mr Iasiello says the centre has in the past five to six years broadened its research scope to domains beyond positive psychology. 'The research is leading to applications in psychological skills training, with increasingly targeted interventions designed for different cohorts,' he says. 'For example, we're working with at-risk youth, youth in alternative education settings, with the Department of Corrections for staff and male and female offenders, the health sector, universities, older adults and in aged care.

'A lot of work has tested whether wellbeing training could be delivered to a range of groups – and evaluation has showed that is certainly true. The next step is to improve the quality of programs to improve results for the participants in these groups, and to tailor them for the individuals themselves.'

Mr Iasiello says the pandemic has forced the centre to look at how it can be most valuable in customising and delivering interventions. 'It's also meant taking what was almost all face-to-face training onto digital delivery platforms,' he says. It started with a program for Flinders University students that had to transfer to an online format; now, a suite of self-assessment surveys and interventions are available online at no cost.

'We are really conscious that COVID-19 is affecting people's mental health,' Mr Iasiello says. 'We wanted to make our services as available as possible.'

With mental health an increasingly prevalent concern amid the pandemic, the 'Be Well' website attracted 15,000 local visitors in the first two months after it launched. Visitors to the site can participate in a survey that assesses their wellbeing and register to participate in intervention programs targeted to any mental health issues indicated by that assessment.

At the same time, the site is collecting data from the participants in four domains: psychological distress (including anxiety, depression and stress), mental wellbeing, resilience and perceptions of physical health. And the findings are clear, Mr Iasiello says: there is a 'significant deterioration' in all four domains since the pandemic began.

A paper published in June showed significantly worse outcomes on all mental health measures for participants measured during COVID-19 compared to those measured before. Participants who demonstrated problematic scores for at least one of the mental health outcomes increased from 58 per cent before COVID-19 to 79 per cent during COVID-19, leading to only 21 per cent of measured participants displaying good mental health during the pandemic.

Mr Iasiello is aware that the sample is 'self-selecting', but points out that pre-COVID participants also fell into that category.

'It is very concerning, but it also makes a lot of sense,' he says. 'The factors that we know contribute to mental wellbeing – social connections, the meaning that comes from employment and security, being able to exercise – many of these are or have been missing.'

SAHMRI researcher Matthew Lasiello

Some good news has already emerged, Mr Iasiello says that in South Australia, wellbeing seems to be 'bouncing back' to pre-COVID levels.

Mr Iasiello says the team is surprised at how quickly this is occurring. 'But it does seem to show the importance of a sense of control and agency,' he says. 'There is an indication that this makes more of a difference than the security of an income. And it does make sense. When it looked as if lockdown may be prolonged in South Australia and we couldn't foresee what would happen to our lifestyle, there was a loss of agency and control.

'That scenario has changed for us in South Australia. And recreation – sports clubs, gyms, the ability to exercise outside – has returned. These have all contributed to wellbeing bouncing back.'

Mr Iasiello is also optimistic about what he is seeing in South Australians' willingness to act to assess and improve their mental health. 'Our work is aiming to get people to have the same level of mental health literacy as they do physical health literacy,' he says. 'People are much more health literate now – they know what they should do to be physically healthy, even if they choose not to do it. We want to reach that status in mental health, and our website and its interventions – which have emerged as the most effective from our meta-analysis of 400 studies of mental health interventions – can play a part in that.'

For more information go to https://mental.jmir.org/2020/6/e20696/. To register for the online measurement platform go to www.bewelltracker.com

South Australian research institutions have responded quickly and flexibly to the demands that COVID-19 has presented. For this issue, we asked the state's three long-standing universities and SAHMRI to summarise the work they are contributing to international efforts to overcome a once-in-a-lifetime challenge.

Roadmap to recovery

Research at the University of Adelaide is looking to a future beyond COVID-19 lockdowns.

Researchers from the University of Adelaide contributed to a major university sector report to help lead Australia out of the initial lockdowns protecting against the COVID-19 pandemic. The 'Roadmap to Recovery', an independent report by the Group of Eight universities to the Federal Government provided expert advice based on world-leading science to help government plot the best path towards social and economic recovery in Australia.

Professor Tracy Merlin, Interim Head of the School of Public Health and Director of Adelaide Health Technology Assessment (AHTA), has been providing advice to governments on public health for the past 20 years. She led the group examining the 'Controlled Adaptation' or suppression option.

'The report provided both federal and state government with a strong evidence base for the difficult decisions that have been needed and continue to be required in the coming weeks and months,' says Professor Merlin.

'The Federal Government and most of the states followed the controlled adaptation strategy outlined in the report and it worked to control the first wave and is still working to suppress the cases in NSW and Queensland.

'Victoria seems to have taken a different route to deal with their second wave – it appears that they are aiming for elimination (which was the other option in the 'Roadmap to Recovery' report). This is an ambitious approach and it will be interesting to see whether it is achievable without too much economic cost.'

RESEARCH TO INFORM HOUSING POLICY

Professor of Housing Research Emma Baker responded quickly to a call by the Australian Housing and Urban Research Institute (AHURI) to examine how the pandemic is affecting Australians who rent their accommodation. Her research group has conducted a national survey of just over 15,000 renting households to collect and analyse experiences of renters during COVID. The report from this nationwide dataset has just gone through peer review and, once published, will help governments make the best housing policy decisions as the pandemic continues.

'The COVID-19 pandemic, and the subsequent economic and social lockdown, has rapidly changed our housing system: the way we use our homes, our ability to afford them, and the role of government safety nets,' Professor Baker says. 'The pandemic has placed many people in the rental market at risk; they face uncertainty, tenure insecurity, financial hardship and significant mental health effects.'

SCIENTISTS UNITE TO FIGHT COVID-19

South Australian virologists, immunologists and clinicians were initially equipped with funding from The Hospital Research Foundation and the Women's and Children's Hospital to commence world-first research into immune responses to COVID-19 infection.

Senior virologist Dr Branka Grubor-Bauk from the University of Adelaide and Basil Hetzel Institute said the team would study the response and recovery of COVID-19 patients to help determine what part of the virus a vaccine should target and what kind of response is required for protection.

This study is now part of a large national collaborative consortium across four states – SA, NSW, Victoria and WA – where an investigation of the virus and host immune determinants of the varied clinical outcomes and potentially protective immunity is undertaken. The collaboration includes the University of Adelaide, University of New South Wales, Monash University, Burnet Institute, Kirby Institute and Garvan Institute, and more than 10 different hospitals across Australia.

VIRUS-SNIFFING DOGS

Researchers are working with international partners to train sniffing dogs to detect COVID-19 infection.

The first COVID-19 detection dogs could be working within months and will complement existing methods by providing low-cost, instantaneous and reliable screening.

Previous research has shown dogs can detect the presence of specific volatile olfactory compounds (VOCs) caused by a viral infection in people.

Dr Anne-Lise Chaber and Dr Susan Hazel from the School of Animal and Veterinary Sciences are coordinating the Australian arm of this international alliance. They say the study will test the sensitivity and specificity of canine detection of VOCs induced by COVID-19 in comparison to those of standard diagnostic testing. Preliminary results have shown specialised working dogs can detect COVID-19 VOCs in patients, with some recording a 100 per cent success rate.

Dogs could eventually be deployed in airports and to screen staff in hospitals and travellers in quarantine.

PREDICTING THE COURSE OF COVID-19

Researchers from the University of Adelaide's School of Mathematical Sciences were part of a national team of experts modelling and analysing early data to predict the course of the COVID-19 pandemic. Applied mathematics lecturer Dr Andrew Black and his team have used mathematics to explain how the curve is flattened. Their work, which initially informed governments' initial lockdown strategies, has moved to the analysis of data emanating from household studies. Modelling will build knowledge around the transmissibility of COVID-19 among household contacts, the role of children in disease transmission, and how to best plan for outbreaks.

The work will help government and health authorities understand how to tackle the spread of the virus without the benefit of a vaccine.

Exploring the seen and unseen

UniSA researchers are investigating virus impacts across many biomedical disciplines.

In a year that had put the world off-balance, University of South Australia researchers have intensified their efforts to apply, adapt and create knowledge to contribute to the global response to COVID-19. From new technologies to the refinement of existing knowledge and experience, the university has responded across a range of fields from molecular biology to mental health.

DETECTING THE VIRUS FROM THE AIR

UniSA Professor of Sensor Systems Javaan Singh Chahl has partnered with a Canadian company, Draganfly Inc, to develop a drone that can remotely monitor and detect people with infectious respiratory conditions.

The drone will be fitted with a specialised sensor and computer vision system that can monitor temperature, heart and respiratory rates, as well as detect people sneezing and coughing in crowds, offices, airports, cruise ships, aged care homes and other places where groups of people may work or congregate.

Prof Chahl, who holds a joint appointment with Defence Science and Technology (DST), is working, to immediately start integrating commercial, medical and government customers.

UNISA JOINS GLOBAL HUNT TO FIND KEY MOLECULE TO BLOCK COVID-19

While the hunt for a vaccine against SARS-CoV-2A is on around the world, less of the limelight is going to the high-potential hunt for prevention strategies.

UniSA molecular biologist Dr Gokhan Cildir is working with a world leader in artificial intelligence-based drug discovery to help find a molecule that could prevent the SARS-CoV-2 coronavirus strain that causes COVID-19 from infecting human cells.

Dr Cildir is collaborating with San Francisco company Atomwise to research the use of artificial intelligence in discovering compounds that could successfully fight SARS-CoV-2.

'Although coronavirus uses many different proteins to replicate and invade cells, the spike protein is the major cell surface protein that it employs to bind to a host receptor — another protein that acts like a doorway into a human cell,' Dr Cildir says.

From millions of molecules screened virtually, Atomwise has identified likely contenders and has sent those compounds to Dr Cildir to test at the Centre for Cancer Biology (CCB) in Adelaide. The goal is to develop inhibitors for the 'spike' protein used by SARS-CoV-2 to invade human cells.

3D PRACTICAL TEACHING TOOL GIVES PODIATRY STUDENTS A STEP UP

When pandemic lockdown forced students to continue their learning from home, some of the intensely practical elements relating to how to teach allied health programs were in jeopardy.

But necessity is the mother of invention, so UniSA podiatry educators, Dr Helen Bramwell and Dr Ryan Causby put their heads together and came up with a foot. A 3D replica made from thermoplastic polyurethane was posted to students, allowing them to learn special practical techniques to treat foot conditions associated with type-2 diabetes.

The rapid innovation was a world-first and had podiatry educators nationally clamouring for the demonstration feet.

ANALYSING THE IMPACT OF COVID-19 ISOLATION ON PREGNANT WOMEN

As most of the professional care bodies around the world disseminated guidelines for pregnancy care in response to the pandemic, the impact of less access to face-to-face care is yet to be seen.

Associate Professor Jane Warland is a UniSA researcher with international expertise in midwifery. She says alarming statistics from the UK have shown up to a four-fold increase in stillbirths at large maternity hospitals during the pandemic.

She says the increase is not due to COVID-19 infections but instead directly related to a reduction in face-to-face checks with mothers, during which blood pressure and other vital health signs can be monitored.

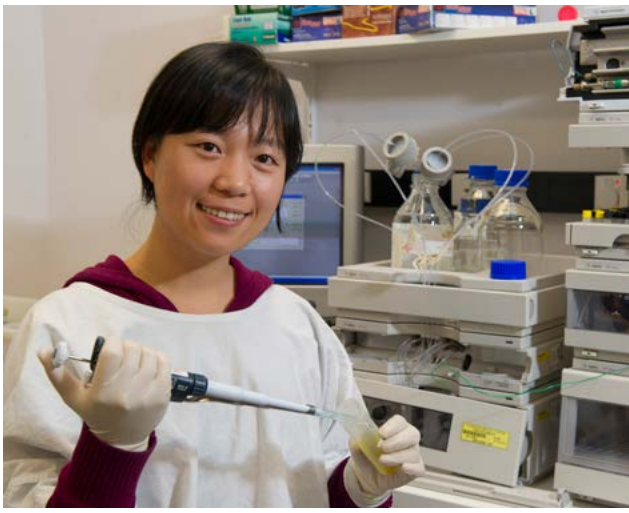
Assoc Prof Warland says fear of the virus and the various restrictions placed on communities around the world have in many instances isolated pregnant women so that symptoms such as high blood pressure, loss of foetal movement and restricted growth have gone undetected.

'We are yet to analyse the impact in Australia, but early results from a survey commissioned by the Australian College of Midwives have shown women – and especially women having their first babies – have felt overlooked and scared for their babies' health, given the lack of regular health checks,' she says.

'With more information to hand, we are hoping to develop alternative options – such as seeing midwives at home – for pregnant women to access perinatal health care during a pandemic, to reduce avoidable still births.'

Vital for our survival

From super antibodies to surgical masks, Flinders University researchers have been fighting COVID-19 one project at a time.



Dr Jing Jing Wang at work in the laboratory.

When word of a new virus started to gain traction in early 2020, opinion was divided on its seriousness – after all, we'd seen novel pathogens emerge in the past, like differing strains of influenza or SARS or MERS; perhaps natural immunity occurs, or vaccines are developed and we continue on, stirred but not shaken. This one is different. The COVID-19 pandemic has demanded innovation and agility of leading researchers to address dramatic loss of life, heavy burdens on our health system and great social, economic and personal disruption around the globe. Just how expansive the challenge is reflected in the extraordinary breadth of research this has demanded of our universities.

A case in point is Flinders University, where, quite apart from the headline-grabbing efforts of a promising vaccine candidate, the complexity of the work required to tackle the impact of COVID-19 is apparent, from innovative mental health assessment, investigating better palliative care options, and assessing the wider impact on the social determinants of health, through to improving protective clothing and masks for both medical personnel and the general public. It covers the clinical, the practical and the conceptual, and it is all vital for our survival and recovery.

A team headed by Nikolai Petrovsky, Flinders University Professor and Research Director at SA company Vaxine, is testing a vaccine candidate against the SARS-CoV-2 coronavirus responsible for the COVID-19 pandemic. Working with Oracle Cloud technology, the researchers identified up to 80 potential candidate drugs against the COVID-19 virus and have commenced Phase 1 trials of their new vaccine candidate called COVAX-19®. Two doses given to each of 40 healthy participants aged between 18 and 65 years at the Royal Adelaide Hospital is the first human trial of a SARS-CoV-2 (COVID-19) vaccine in the Southern Hemisphere; the results will be available for peer review within weeks.

While the world waits anxiously for a vaccine to fight COVID-19, another team is working to 'fingerprint' the repertoire of antibodies that develop following the disease. Led by Dr Jing Jing Wang, Professor David Gordon and Professor Tom Gordon, the team has been given blood samples from 30 former COVID-19 positive patients in a bid to pinpoint 'super-antibodies' that may create long-term immunity against future virus infection. The work involves identifying and purifying the COVID-19 specific antibodies from blood and determining their protein sequences by using mass spectrometry technique, which is being performed in collaboration with Dr Tim Chataway from the Flinders Proteomics Facility.

Flinders researchers are also endeavouring to find a link between bacterial pathogens and predisposition to severe COVID-19 infections, which will explain why acute Respiratory Distress Syndrome in more than 50 per cent of patients who die with COVID-19 have associated co-infection with bacterial pathogens.

Lead researcher Dr Bart Eijkelkamp from the Bacterial Host Adaptation Research Laboratory and other medical experts at Flinders are focusing on the role of bacterial infection before a person becomes infected with the SARS-CoV-2 virus – to understand what impact these pathogens have on respiratory failure.

Aside from fighting the virus itself, there's also a focus on safety, especially for medical staff and others at the front line. Flinders has been instrumental in establishing Australia's first dedicated testing facility for protective gowns, to ensure more locally made personal protective equipment (PPE) is available that can keep healthcare workers safe from COVID-19 and other infections.

Medical Device Research Institute (MDRI) researchers at Flinders at Tonsley are testing fabric samples from gown manufacturers for resistance to bacteria, virus and fluids. This builds on a collaboration between the State Government, Flinders University and UniSA to develop the South Australian Mask Testing Facility at Tonsley to test respirator and surgical masks produced by local manufacturer Detmold. MDRI director Professor Karen Reynolds says serious disruption of PPE supplies during the COVID-19 pandemic showed it was now more important than ever to establish an Australian-based gown testing facility.

Another innovative trial at Flinders Medical Centre is testing 3D-printed face mask seals moulded to the faces of individual healthcare workers, to reduce the potential for any infection caused by ill-fitting masks.

Beyond serving the medical community, Flinders University's tests of commonly available fabric masks have proved they significantly reduce the number of aerosolised viruses a wearer could be exposed to. The study, published in *Pathogens*, found even the poorest performing mask filtered at least 63 per cent of virus numbers in aerosols of a size produced by coughing and small enough to be inhaled into the lower respiratory system.

This research is among a raft of 35 COVID-19 related projects active across Flinders University's six colleges, some in collaboration with external partners. They touch myriad aspects of society, recognising that social detriments caused by COVID-19 are greatly affecting the general community, not just those afflicted by the disease. An extensive study by the Órama Institute for Mental Health and Wellbeing will analyse the

mental health and wellbeing of South Australians before and after the onset of COVID-19, to gain insights into where public health support should be directed.

Meanwhile, the Caring Futures Institute is exploring how the pandemic has impacted everyday life including physical activity patterns, sleep and the dietary intake of Australian families. Led by nutrition expert and CFI's *Better Lives* theme lead Professor Rebecca Golley, researchers will look at how Australian parents and caregivers are managing family life during COVID-19, and the pandemic's impact on parents' self-care behaviours.

It doesn't end there. Flinders researchers are evaluating a home telemonitoring program for patients with chronic conditions during isolation, conducting sewage monitoring as a means of detecting outbreaks, investigating traumatic stressors, examining the lasting effect of the pandemic on youth sport, and identifying cultural understandings of COVID-19 in remote Aboriginal communities. The importance of robust research that informs and elucidates cannot be understated.

SAHMRI pivots to tackle COVID-19

South Australian Health and Medical Research Institute researchers have quickly turned their attention to responding to the health impacts of COVID-19.

With the world as we knew it changing at pace earlier this year COVID-19 was affecting lives, livelihoods and even language.

Research was by no means immune from the upheaval, and while the first obligation of those at the South Australian Health and Medical Research Institute (SAHMRI) was to protect and proceed with ongoing projects, many researchers quickly turned their attention to the global COVID-19 response.

The breadth of SAHMRI's research has been brought to bear across basic science, genetic sequencing, behavioural science, mental health assessment and training, clinical trials and collaborations with local, national and international researchers.

The Wellbeing and Resilience Centre at SAHMRI was one of the first groups to react to the situation, rapidly retooling its renowned evidence-based mental health training as a preventative measure against escalating anxiety brought about by the pandemic and associated fallout.

SAHMRI made international headlines in April when, in partnership with SA Health, it became the South Australian lead on the international BRACE Trial. Led by the Murdoch Children's Research Institute in Melbourne, this clinical trial is investigating whether BCG (the long-established tuberculosis vaccine) can provide an immunity boost to reduce the prevalence or severity of COVID-19 symptoms.

Another partnership with SA Health, which also included the University of Adelaide and Melbourne's Doherty Institute, investigated the infectiousness and severity of COVID-19 during the first few days after infection. The FFX Study, as it was known, provided invaluable understanding of how the virus spread and affected people.

At the molecular level, SAHMRI researchers began preparing for those people who, for one reason or another, will not be able to receive a COVID-19 vaccine even if one is developed. They identified the unique component of COVID-19 responsible for hijacking the cell's protein production system and have developed a novel strategy to rapidly generate compounds which can effectively block the viral attack.

With the virus still in its infancy and thorough hygiene measures the best, if not only, defence against its rapid spread, a SAHMRI team fast-tracked a public health awareness campaign leveraging the public profiles of Adelaide Crows coach Matthew Nicks and Port Adelaide defender Hamish Hartlett. The project sought to both boost adherence to hygiene guidelines and measure the impact 'influencers' like Nicks and Hartlett may have over and above regular public health messaging.

The availability of ventilators amid a projected spike in demand was another key issue as the virus took hold around the world. The SAHMRI-based Registry of Senior Australians galvinised its data analysis expertise to examine historical incidence of viral pneumonia among the residential aged-care population. The team analysed whether ventilators or intubations were needed, whether cases were escalated to intensive care and why, the average length of hospital stay, rates of readmission and number of deaths. This information gave health authorities baseline data on which to estimate the system's available capacity.

SAHMRI Executive Director Professor Steve Wesselingh

While older people were quickly recognised as particularly vulnerable to COVID-19, other groups were soon identified as susceptible. SAHMRI's world-renowned chronic myeloid leukaemia (CML) research team directed a global survey of people with CML, assessing the impact immune-suppressing therapies could have. This information was developed into detailed, evidence-based guidelines for clinicians and patients around the world.

SAHMRI's Executive Director and infectious diseases specialist, Professor Steve Wesselingh, has also provided expertise, helping the public navigate the huge volumes of information, while the institute's Health Policy Centre continues to inform South Australia's official response through cooperation with the Commission on Excellence and Innovation in Health.

A new leaf in the portfolio

On learning as a young medical student that fewer than 10 per cent of medical students would become specialists, the now notable surgeon, researcher, and company director Associate Professor Susan Neuhaus AM CSC nearly washed her hands of all hope of being one of them.

But now, reflecting on a stellar career that has taken her from commanding soldiers, to working in a military base hospital in Afghanistan, accepting an Australia Day honour, a PhD in the mechanisms that spread cancer, positions on a string of boards, and a recent appointment as President of the SA/NT Division of the Institute of Company Directors, some clear themes emerge.

One is a sense of good fortune and a sense of obligation associated with it – and a willingness to walk through the sliding doors that open.

'I've been very fortunate in a combination of things. I'm very conscious of the fact that I come – so many of us come – from a position of immense privilege. It's a privilege that we don't spend enough time thinking about but is really brought into perspective when you serve overseas. Certainly, you could not be happier to be in South Australia at the moment.

Dr Susan Neuhaus reflects on a portfolio career as celebrated researcher, surgeon and company director

'I'm also of the era where I had a free university education, and I think it does shape your values – you do feel the need to give back for that,' Dr Neuhaus explains.

She considers this perspective may also have influenced her decision as a young graduate to join the military where she was galvanised into leadership roles.

Dr Neuhaus was first posted as a doctor overseas in 1993, spending nine months with the United Nations Transitional Authority in Cambodia as the Australian Regimental Medical Officer, followed by stints commanding a tented hospital in Bougainville and as a surgeon in Afghanistan. She retired from the Army in 2011 at the rank of Colonel.

'I'm not sure why I did [join the army]. I thought I would be doing tropical disease or something. I joined up at the end of the "Long Peace" – it was a peace time army in the 1980s. I certainly didn't expect that at the age of 27 I would find myself overseas running a facility with 350 soldiers from Australia and New Zealand scattered right across a war-torn country, or running a malaria research lab. I guess the dice fall and you roll with them.'

She recalls 1993 as an especially difficult year.

'When I look back, I can see that I couldn't have done the next roles unless I'd had those experiences or learned the lessons – although you don't necessarily realise that at the time you are learning them,' Dr Neuhaus says.

'Afghanistan was a lifetime after that, but by that stage I was a consultant surgeon and I'd also commanded a military hospital; I'd had other life experiences including having two children and a few other things.

'Perhaps there's a career pattern there, but when you look forwards you don't really have any idea about the doors that will open for you. There are always doors that open, if you have the courage to walk through them. Not all of them take you to a good place, but every experience helps you grow and learn, introduces you to new ways of thinking and makes you just a little bit wiser.'

It was the experience as a mother of young girls deploying overseas that lead to research which, in part, led to her being appointed a Member of the Order of Australia in 2020 for services to medicine and veterans and their families.

'One of the things that concerned me when I came home was that international research suggested women who deployed and left kids at home were at high risk of having post-traumatic stress disorder (PTSD). I got quite concerned about that and thought that just can't be right. That's one of the things that led to the 'Mothers Study'. It is a huge piece of work and I can't really claim credit for it - it was a whole team over many years, conducted through the Centre for Traumatic Stress Studies and, in part, funded by the Department of Veterans' Affairs.

'What it ended up showing is Australian women with children who chose to deploy were highly organised, high-functioning people who put lots of systems in place for themselves and for their families so it wasn't a big risk for them psychologically.'

> ***… The pandemic environment has highlighted the need for strong systems in organisations that promote ongoing improvement, rather than systems for their own sake …***

The research team has gone on to explore the gender-based physical impacts of deployment and

Dr Neuhaus continues to supervise research in the field, including fertility impacts of overseas service.

And in the same way the research has evolved, Dr Neuhaus' career has transitioned to a focus on company directorships. She has spent more than a decade immersed in leadership roles with the Royal Australasian College of Surgeons Court of Examiners, AMA Federal Council and with board roles in a not-for-profits, including as the current Chair of the Veterans Advisory Council SA.

Dr Neuhaus has recently been announced as President and Chair of the SA-NT Division of the Australian Institute of Company Directors (AICD) and continues on a number of small commercial and defence boards. One is the Australian War Memorial Council, which is overseeing a $500 million renovation of the iconic memorial.

Passionate about good governance and seizing the opportunities that are emerging in South Australia and the Northern Territory – particularly around new technologies – Dr Neuhaus is filled with optimism for the future, despite this year's COVID-19 setback.

'From a South Australian perspective, we have so many opportunities in terms of aerospace, defence industries, the AC3 cyber collaboration and what's being done in the innovation space at Lot 14. We have the potential to be on the front foot and be leading, not just the state, but leading nationally and in some areas, internationally,' she says.

Former AMA President Dr Tony Bartone congratulates Dr Neuhaus on her AMA Fellowship at the 2019 National Conference

The pandemic has forced people in many sectors to look at how they do business, Dr Neuhaus says.

'The pandemic environment has highlighted the need for strong systems in organisations that promote ongoing improvement, rather than systems for their own sake, and has reinforced the need to be flexible and adaptable to the environment,' she says. (And) it's challenged us to look at the component parts from the way our Federation works down to our supply chains and how they relate to each other. How much can you trust people and enable component parts to take on new or different roles?

'What this is showing us is the importance of a focus on strategy, contingency planning, being able to understand the drivers of your business, and the way you can turn parts of your organisation on and off.'

Identifying and managing the components will be even more important in a post-pandemic world, Dr Neuhaus says.

'This is something that medicine is familiar with – the need to constantly adapt in the face of new emerging evidence. In my world of surgery for example, some of the operations that kept me up late as a registrar aren't even performed anymore. They've been replaced by cleverer technologies or in some cases by non-surgical solutions such as drug therapies.

'Governance roles are no different – we all need to adapt to new and changing environments and to changing expectations and standards in the community.

'This has been highlighted by the failures of the heavily regulated aged care sector, which has not been successful in protecting residents despite the emphasis on accreditation. Now we're going to see much greater emphasis on education and proactive governance rather than reliance on reactive compliance-driven measures. Good governance makes us all stronger; it makes our boards and companies perform better. In return, society is better, too.'

It's clear that this notion of constant improvement, in both self and society, is the leitmotif of Dr Neuhaus's career.

'I've just been really privileged – I've had a portfolio career and been able to do work across a number of different fields,' she says. 'That's provided me a with a cross-disciplinary lens and a more global mindset, but if I've had success, it's not just down to me but to all my colleagues, including my medical colleagues, who have encouraged, coerced and (sometimes) cajoled me along the way.'

Civil actions

The pandemic has changed the way lawyers and doctors work together, writes Law Society of SA President Tim White.

The COVID-19 pandemic has brought about significant changes to the ways in which lawyers now work. Our interactions with clients, fellow practitioners, doctors and the courts are vastly different to pre-March 2020. Court trials are being conducted over video conferencing with witnesses and the parties appearing remotely. Lawyers are taking instructions from clients in prison via Zoom. Documents can be signed digitally. Wills and other estate documents are being prepared during Zoom meetings.

Just as COVID-19 enabled the expansion of telehealth to occur in Australia at unthinkable speed, these are changes to our systems and practices that would otherwise have taken decades to be agreed and implemented. Instead, they have occurred over a matter of weeks.

In addition to dealing with the challenges from the pandemic, lawyers in SA also had to deal with new Uniform Civil Rules for the civil jurisdiction and an electronic-based court filing system. Both started in May and significantly changed the format and the way in which court documents are filed. The Rules also change the procedures and ways civil litigation is conducted.

The changes have ramifications for how lawyers request expert opinions from doctors. The Uniform Civil Rules that apply to matters being litigated in the Supreme, District and Magistrates Courts also impact on all experts providing reports to parties in these jurisdictions. The Rules are much more descriptive in relation to what expert reports must now contain, and the documentation that lawyers must provide to experts has altered.

When a lawyer seeks a report from a doctor they must now attach a part of Chapter 7 of the Rules that sets out what the doctor needs to refer to in the report.

Rule 74.2 (below) sets out the material a lawyer must provide to you when requesting a report:

74.2—Letter requesting expert report

(1) A party who requests an expert to provide an expert report must, within 7 days of arranging for the expert to provide an expert report, send a letter to the expert—

(a) setting out the assumptions the expert is requested to make for the purpose of expressing an opinion;

(b) setting out any investigations the expert is requested to make for the purpose of expressing an opinion;

(c) setting out the materials provided to the expert for the purpose of expressing an opinion;

(d) setting out the questions on which the expert is asked to express an opinion; and

(e) attaching a copy of this Part.

(2) A party who requests an expert to provide an expert report must, within 7 days of sending a letter to the expert under subrule (1), serve on each party to the proceeding a copy of the letter.

Note —

Merely retaining an expert for a proceeding without providing any substantive instructions to the expert does not constitute arranging for the expert to provide an expert report for the purposes of subrule (1). 74

Rule 74.10 details the material that an expert must include in their report for it to be compliant with the new Rules.

74.10—Content of report

An expert report prepared by an expert must—

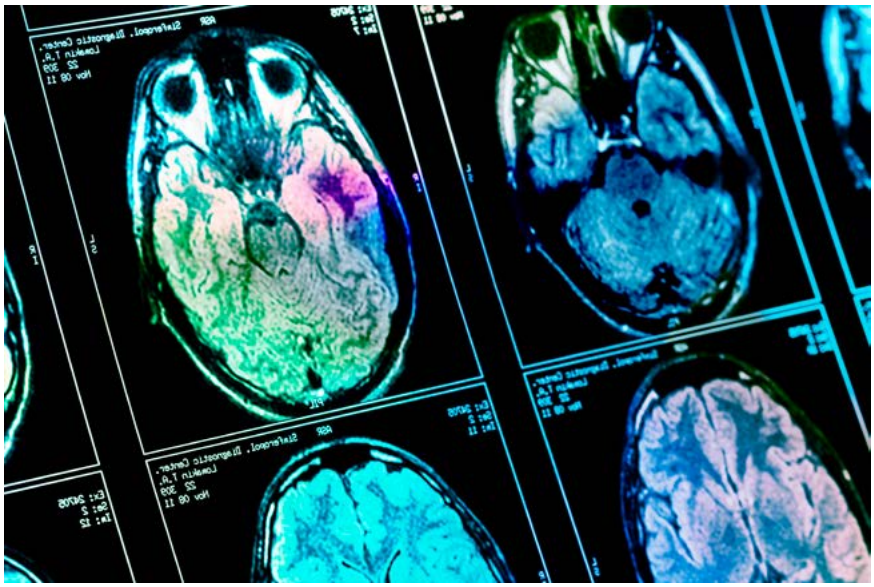
(a) state clearly the opinion, or opinions, of the expert;

(b) state the name and address of the expert;

(c) include an acknowledgment that the expert has read this Part and agrees to be bound by its provisions;

(d) state the qualifications of the expert to prepare the report;

(e) state the assumptions and material facts on which each opinion



expressed in the report is based (whether by annexing a letter of instructions or otherwise);

(f) identify the reasons for, and any literature or other materials utilised in support of, such opinion;

(g) state (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;

(h) identify any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;

(i) to the extent to which any opinion that the expert has expressed involves the acceptance of another person's opinion, identify that other person and the opinion expressed by that other person;

(j) include a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the knowledge of the expert, been withheld from the Court;

(k) state any qualifications on an opinion expressed in the report without which the report is, or may be, incomplete or inaccurate;

(l) state whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason;

(m) where the report is lengthy or complex, include a brief summary of the report at the beginning of the report;

(n) identify documents and other materials that the expert has been asked to consider (whether by annexing a letter of instructions or otherwise);

(o) attach copies of documents that record instructions given to the expert; and

(p) be signed by the expert.

As above there are now 16 elements that a doctor must include for a report to comply with the Civil Rules. If a report does not comply with these aspects, it is likely it will not be able to be used.

It is important that you are aware of these somewhat recent changes and what is now required to be included in reports prepared for matters in the Supreme, District and Magistrates courts.

More information about the changes to expert report requirements can be obtained by emailing the Law Society's Ethics and Practice Enquiry Service at ethicsandpractice@lawsocietysa.asn.au

Assessing permanent impairment

The AMA(SA) Medico-Legal Advisory Group has been advised of several recent decisions of the South Australian Employment Tribunal (the SAET) relating to the actions of ReturntoWork SA (RTWSA) regarding permanent impairment assessment reports, under s22 of the Return to Work Act (SA).

The Full Bench of the SAET, in the case of Frkic v Return to Work Corporation of South Australia [2020] SAET 16, considered RTWSA's practice of writing to doctors who have been chosen as accredited assessors and (in the compliance process) asking them to reconsider/amend their reports; and to not pay them until RTWSA is satisfied their reports are compliant.

The SAET decided such actions by RTWSA can trigger the exercise of the discretion referred to in decisions such as Bunning v Cross (1978) 141 CLR 54 and may result in the exclusion of subsequent and modified reports.

The SAET decided that RTWSA can raise questions in relation to a doctor's permanent impairment assessment report and seek clarification – as long as RTWSA includes the worker or their lawyer in those emails/requests. However, RTWSA must not insist that a medical practitioner change their permanent impairment assessment report, or coerce them to do so, as part of the review process.

The Full Bench also heavily criticised RTWSA's practice of withholding of payment for a permanent impairment assessment report while it is questioning aspects of the report. The Committee understands RTWSA is no longer withholding payment in these circumstances.

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Responding to the unknown

A 2020 update on radiology should have focused on artificial intelligence – but then a virus changed everything, writes AMA(SA) Councillor Dr Jill Robinson.

Dr Jill Robinson

In a 'normal' year, an update on radiology in 2020 would have focused on the momentum of artificial intelligence (AI) and the implementation of deep learning models. Most radiologists support AI and believe it will enable greater efficiency and accuracy. It has generated a mixed response among our potential trainees, some of whom clearly believe that we should stop training radiologists, and this has impeded recruitment into the specialty.

However, true to the old Danish proverb – 'Making predictions is hard, especially about the future' – who could have predicted that the AI takeover of radiology would be upstaged by COVID-19?

Of course, the pandemic has had a huge impact on all medical practice, but many outcomes in radiology have been positive. Social distancing at reception has created a calm waiting room with no seething masses, just one family member or carer (or preferably no one) to accompany the patient. We have quiet distancing queues and car-park messaging. Reception screens are mixed blessings, though. How many ways can patients break social distancing? Well, they can lean on the screen, put their heads around the screen, or try to limbo dance under the gap in the screen. Further suggestions are not welcome.

Electronic referrals have populated our branches, minimising the transport of vile body fluids and other unknowns through our existing paper requests. There is efficient throughput of patients who can leave without signing if bulkbilled. Examinations are streamlined. Our technical staff are less crowded in our viewing areas (although conditions are not ideal) but social distancing has not quelled their *joie de vivre*!

Electronic messaging has become the new norm. Inteleviewer links and chats have replaced the casual 'swing by' into the radiologist's office. We clearly welcome our fellow radiologists' dry social commentaries on their day on our chatlines, but radiographer-generated messages and patient links can quickly accumulate on call. The record is 40 simultaneous 'chats' all blinking at once – yikes!

> ***'Making predictions is hard, especially about the future.'***
>
> ***- Old Danish proverb***

Social distancing with our referrers has been more erratic in our multidisciplinary clinics but gone are the pieces of paper with illegible names and a scribbled 'NAD' (no abnormality detected). Google SLACK (Google team collaboration) – known in our circles as 'SLAP' – communication is here!

COVID-19 has accelerated teleradiology reporting in a very positive fashion. Hats off to our IT department, competing for and installing monitors and home reporting stations and fielding our IT issues. Radiologists can be high maintenance on this front. We can now self-quarantine and work from home. We can work after hours from home. too. Positives and negatives have occurred on work-life balance, but we have been supported by the use of excellent Victorian radiologists to help with our ever-increasing workload.

Multidisciplinary team meetings (MDTs) are now Zoom meetings and there are mixed blessings here. I miss the collegiate slurping of coffee during our early morning meetings. Multi-tasking reigns with 'live' inteleviewer radiology presentation, loading up Windows in advance, straining to hear the audio through our speech mikes. Ambiguity prevails: please don't change the order…to mute or unmute, share or stop sharing the screen. Bring back the bacon sandwiches and harmonious PowerPoint.

We've had no exams for our Part II Fellowship registrars but that's only a temporary glitch. They will now face our local examiners in November. Good luck to all.

Radiologists have perfected the art of conference travel, so adjustments have been made. Now there are no flight delays, jet lag, pressure or the thrill of an unknown urban destination.

So back to the original thread. To those potential recruits who feel that radiologists are akin to coyotes already over the edge of the cliff who won't look down, please reconsider. We welcome bright, worldly people who retain an excellent sense of humour and good typing skills – especially when they are diving off a cliff…

Banja J. (2020) AI Hype and Radiology: A Plea for Realism and Accuracy Radiology: Ar@ficial Intelligence; 2(4):e190223

Dr Jill Robinson is a partner at Benson Radiology and Senior VMO at Breastscreen SA

AMA SOUTH AUSTRALIA

AMA(SA) Council Meeting September 2020

An agreed need for more clinicians' involvement in planning the proposed Women's and Children's Hospital and issues relating to difficulties transferring regional patients into metropolitan hospitals dominated discussion at the AMA(SA) Council's September meeting.

The meeting was again conducted with the help of Zoom technology, with only President Dr Chris Moy and Vice President and Council Chair Dr Michelle Atchison joining CEO Dr Samantha Mead and other Secretariat staff in the AMA(SA)'s Dulwich boardroom.

Participating members were joined by observer Dr David Lam, a Port Lincoln GP who joined the AMA after seeing its active support for rural health issues and its high-profile advocacy for doctors during the unforeseen events of 2020.

Discussion again largely revolved around COVID-19 and the work being done at the national and state levels and within communities to support members, healthcare workers and patients through the health, professional and financial impacts of the pandemic.

Dr Moy reported that he had suggested to Health and Wellbeing Minister Stephen Wade in the Minister's regular meeting with AMA(SA) leadership that looking to more than one local supplier of masks was a logical way of managing risk, particularly with increased demand from health care workers for equipment that would alleviate their concerns about virus spread.

Dr Moy also noted that the Federal AMA continues to advocate for the continuation of expanded telehealth measures beyond the pandemic.

Locally, Dr Moy said, he had been lobbying the government to help several South Australian medical students gain exemptions from lockdown restrictions and return to the state.

In relation to planning for the new WCH, Councillors noted that there had been inadequate funding and resources made available to 'free up' clinicians to give their time and expertise to the process, and to ensuring expert input was being considered. Councillor and gynaecologist Dr Jane Zhang pointed out that obstetricians, in particular, are hard to 'pin down' for meetings that may be part of a 'once in a lifetime' opportunity to plan a world-class hospital for South Australia's women and children because of the unpredictability of timing of obstetric deliveries.

Equally impassioned debate occurred after the Council's rural representatives explained the financial and health implications of issues relating to transferring patients through ambulance and RFDS between regional areas and metropolitan hospitals.

Dr Atchison reported on progress updating the AMA(SA) Constitution, which Dr Mead is leading with Council and Board guidance.

Council's next meeting is scheduled for Thursday, 5 November.

New priorities

Marion PCC Dr Andrew Brooker and RN Jacqueline Quarrell with a patient

Four Priority Care Centres (PCCs) have been established across metropolitan Adelaide to provide single episodic care.

The care is provided by general practitioners (GPs), with support from SA Health nurses, to people with urgent, low acuity conditions who would otherwise attend an emergency department (ED).

PCCs are located in Marion, Hindmarsh, Para Hills and Elizabeth, near Adelaide's busiest EDs. Between when they began operating in August 2019 and 20 September 2020, 5,670 people have been treated at PCCs, with an average service wait time of 10 minutes.

Common conditions managed by PCCs include suspected or confirmed simple fractures requiring back-slabs or splinting, wounds and lacerations, including suturing or incision and drainage; ear, nose and throat (ENT) foreign bodies; urinary tract infections; cellulitis; and other infections requiring intravenous antibiotics.

All PCCs have access to pathology, radiology and pharmacy services, and can facilitate referral to other community-based services and outpatient clinics as required.

GPs who are unable to provide their patients with access to urgent face-to-face consultations have been able to provide them with the option to attend a PCC rather than ED.

The PCC model ensures patient suitability, quality and safety through agreed pathways, with a range of more complex presenting conditions excluded. Suitability for a PCC service is confirmed via direct discussion with the PCC. People can be offered the option of accessing a PCC by SA Ambulance, a metropolitan ED, a person's own GP, or Local Health Network community-based services.

PCCs discharge all patients back to their usual GPs, with discharge summaries and care entered into My Health Record.

As well as reducing the service wait times for patients, the service is also popular with those who work in them. Para Hills PCC GP Dr Jeremy Seow says he enjoys working in the PCC.

'It allows more time for a wider range of treatments, with great support from local hospital specialists through speedy advice and early reviews, if required,' Dr Seow says.

PCCs are a partnership between SA Health, Wellbeing SA, the Adelaide Primary Health Network and GP Practices.

For more information see the Priority Care Centres page on the SA Health website or email WellbeingSAPriorityCareCentres@sa.gov.au.

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Campaigning for care

The AMA(SA) is passionate about bringing together all South Australia's doctors, focusing on what unites us as we work together for the greater good of the medical profession, and all South Australians.

The AMA's advocacy for doctors and patients has never been more important than during the COVID-19 pandemic – a period in which doctors have faced intensive personal, professional and financial stressors and challenges.

As an AMA (SA) member you are contributing to the advocacy the AMA has provided at state and national levels, supporting doctors and colleagues and patients through this long and distressing period. Your support has made it possible for us to achieve all that we have for doctors and the wider community, which recently includes:

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

You also have opportunities to connect with colleagues across all medical professions, to learn and share how you are addressing the challenges while continuing your medical and other professional roles and supporting your patients.

Looking after you

Whether you are a medical student, starting out in your career, establishing your own practice, working in a large hospital or remote community, the AMA is here to support you.

As an AMA (SA) member you have access to a range of free and discounted resources and services to support you, plus professional development opportunities, and advice on workplace and career matters.

One of the benefits is the access to the AMA List of Medical Services and Fees, which costs $499 if you are not a member. Another important benefit is the free subscription to the *Medical Journal of Australia* (MJA). If you are a doctor employed in a South Australian public hospital, you may be able to include your membership in your professional development allocation. Other member benefits include:

- discounted services from Hood Sweeney and Norman Waterhouse Lawyers
- access to Mercedes-Benz and Volkswagen corporate programs
- discounted accredited training with our AMA Skills Training team
- free use of the doctorportal Learning CPD Tracker
- discounted subscriptions to the iWonder documentary and current affairs streaming service.

We're fighting COVID-19 together. Please join us to strengthen your voice, and ours.

ALL ABOARD

It's coming up to membership renewal time.
Please check that we have your correct contact details, so we reach you with the renewal information.
To update your details, please log into your membership portal at members.amasa.org.au, or contact us at membership@amasa.org.au or phone 8361 0108. Please let us know if your membership category or circumstances have changed, so we can update your records accordingly.

Oaths, to take or not to take?

LIAM RAMSEY
STUDENT NEWS:
FLINDERS UNIVERSITY

How many of you can recite the Hippocratic Oath? I know I certainly cannot. In fact, I only recently read the original and later iterations – not for leisure reading, but, as I approach graduation and my oath-taking ceremony, I wanted to better understand what was (once) a profession-defining document. I wanted to read it and grasp its core principles, the way physicians were defined, and whether I could align my professional identity with it.

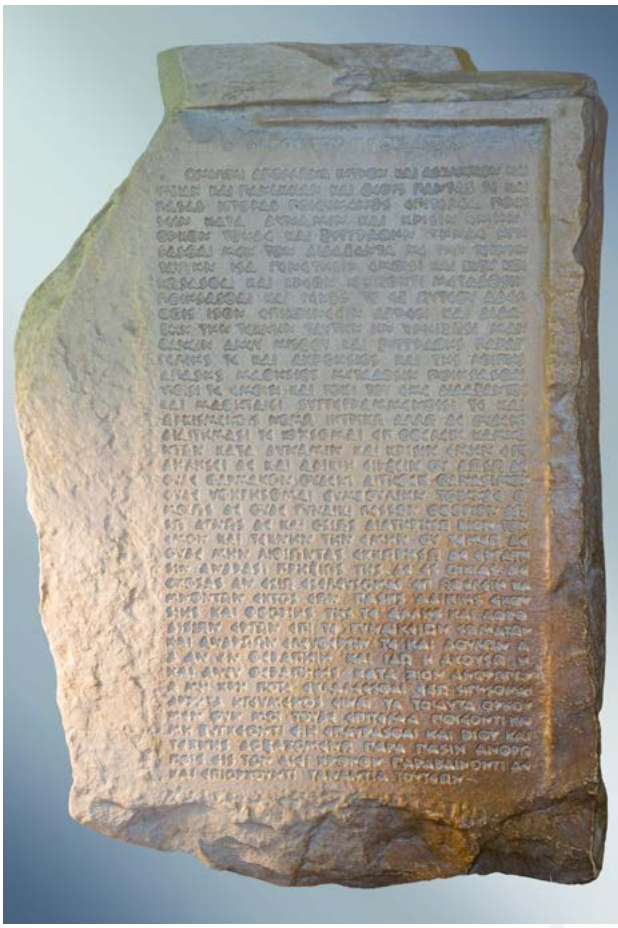
The Hippocratic Oath is an ethical code historically taken by physicians at the end of medical school. It was written between the fifth and third centuries BC and many attribute the work to Hippocrates (although there is much debate about this claim). The text reinforces the need for knowledge, respect for teachers, and the use of medicine and diet to treat illness; that doctors should avoid harming patients and maintain their confidentiality; that surgeons are necessary. These directives do not conflict with most of our modern-day values. However, a declaration of faith to Greek deities aside, there are contentious statements in the original oath, which (for example) goes on to prohibit doctors from participating in abortion and euthanasia.

Two thousand years later and we still struggle with allowing people absolute autonomy over their bodies and futures. Abortion, the medical or surgical termination of early pregnancy, is now common; statistics indicate one-fifth of all Australian women have undergone the procedure. It's broadly supported by Australian doctors and we have seen major shifts to better empower women and provide better care. However, euthanasia sparks divergent opinions in the medical field; look no further than the 2016 AMA Position Statement on Euthanasia and Physician-Assisted Suicide.

While the original Hippocratic Oath addresses some aspects of modern medicine, it falls short in being unable to reflect many social and ethical gains made in the last 2,000 years. Namely, the Oath implies the medical patriarchy has control over patients' bodies, failing to recognise patients as autonomous and knowledgeable custodians of their own bodies. It fails to encourage patient empowerment through educating and enabling patients to manage their medical conditions. The Oath doesn't work to recognise the human beneath the disease and the complex social-cultural needs that underpin patients' sense of wellbeing.

In a pre-lab world, it couldn't possibly mention the need for restraint and measured intent when ordering and billing patients for tests and treatments. It fails to recognise barriers to healthcare and systematic discrimination of patients for their class, race, sex, gender, and educational status, as these issues were not considered important at the time. Given the hierarchical and discriminatory ancient society in which it was developed, the Oath could not foreshadow our contemporary belief that class shouldn't impede treatment to healthcare – a belief we now define as a right. Neither could it predict the need for participants' rights in medical research, which are now ethical requirements of trials and studies. It also fails to mention the need for doctors to abstain from practice when physically or mentally unwell. Admittedly, many of these issues have been addressed in new iterations such as the updated World Medical Association Declaration of Geneva, which I implore you all to read.

The question then becomes why do we take oaths? Tradition is paramount for doctors; otherwise, why do you see them all examining from the right side of the bed? It reinforces collegiality and a sense of belonging in a profession. An oath holds merit in reinforcing core values crucial to our practice, which is centred on being strong for the vulnerable. Tradition also holds us accountable, so while criticising old oaths is quite easy, these decrees must be contextualised. The challenge becomes addressing our own 'oaths' so that we continually re-evaluate what is important to us and what drives our practice.



The original Hippocratic Oath

Since its inception 2,000 years ago we have seen multiple iterations of the Hippocratic Oath. It is becoming a fluid and dynamic set of values that ceremoniously marks the end of medical school and the beginning of medical practice. It should serve as a mechanism to contextualise the environment in which a class of medical students has studied and thrived.

We could utilise oaths as a means to continually redefine ourselves and strive to improve our core beliefs.

Despite all the flaws with oaths and generalising statements I look forward to taking one at the end of the year. Firstly, because in that moment I will feel a sense of accomplishment and connection to my peers. Secondly, because I hope 25 years from now a cheeky medical student will criticise the oath I have recited, too!

Sighing a long-awaited sense of relief

JADE PISANIELLO
STUDENT NEWS:
ADELAIDE UNIVERSITY

The students of the Adelaide Medical School have settled back into the realm of normalcy in recent weeks with students across all six years of the program relishing the return to clinical placement and in-person teaching as well as the resumption of some Adelaide Medical Students' Society (AMSS) social events!

Sadly, our most anticipated and enthusiastically attended event of the social calendar, MedBall, was cancelled due to COVID. Nonetheless, the AMSS has continued to deliver events for members. We successfully showcased the theatrical and musical talents of our students during early September with three live and sold out performances of MedRevue – 'How I Med Your Mother'. The three-hour long musical, held in Scott Theatre, featured an original script with an accompanying 17-piece band. It told the story of a young boy and girl about to start medical school at The University of Adelaide, both of whom had to endure their father telling them (with significant jest) about his time as a medical student many moons ago… in the year 2020! We have also had different year levels battle it out in 'Inter-Year Comedy Debating'. We stood together and reflected on mental health during Health and Wellbeing Week and welcomed in a new AMSS Executive and Committee for next year at the Annual General Meeting.

Although there are still a few more weeks of the academic year ahead of students in years 1-5, for those in final year the end is well and truly in sight, with just a few days left for some of our sixth years. With the easing of restrictions and venue capacity limits rising, the AMSS is able to deliver the long-awaited and well-deserved events attached to 'Graduation Week'. Of these, the most significant is the Declaration Ceremony, where the Class of 2020 will commemorate six long years of study in front of appropriately distanced faculty staff and parents, and they will commit themselves to the service of others as doctors.

As the sixth years start to pick out their very best suits and dresses for GradWeek, the pre-clinical students across years 1-3 are preparing to sit their exams away from the usual venue, Wayville Showground, with the faculty planning on delivering assessment online. For students in year four and those sitting their exit examinations in year five, assessment will still be delivered in person. The two-day fifth year OSCE, affectionately referred to (by me) as the 'hardest 48 hours of medical school', will occur face-to-face, in all its glory, at the medical school in mid-November.

As we come to the end of what has been a very tumultuous year, I think I am not the only one beginning to sigh a long-awaited sense of relief (touching wood as I do so!). The last few months have been full of highs and, mostly, lows. Although coronavirus has affected almost every part of the AMSS and the joy the society is normally able to bring to students, the collegiality among medical students could not be swayed by a mere pandemic. I hope this mutual support is something we are able to carry with us throughout our careers – which, for some of us, are due to begin in 12 short weeks!

Men's experiences to transform prostate care

Movember is launching the world's largest network of prostate cancer patient registries.

It is hoped the registries will transform treatment and care of the disease by harnessing the 'real world' experiences of more than 130,000 men.

The global 'super network' – believed to be the first of its kind – will contain detailed clinical information on the diagnosis, treatment and survivorship of prostate cancer patients from 15 or more countries around the world.

Movember is aiming to expand the network to include data on 250,000 men within the next five years, accelerating its efforts to improve the treatment and care for men diagnosed and living with prostate cancer.

Paul Villanti, executive director of programs at Movember, says the data will enable prostate clinicians throughout the world to measure and benchmark the health of their patients after treatment, providing them with vital information to improve the quality of prostate cancer treatment and care.

The patient registries will deliver personalised care to more men as the data will allow cancer specialists to monitor how patients are responding to new generations of therapies in the real world, outside of clinical trials.

It will enable researchers to fast -track the implementation of clinical trials that enable us to understand which new therapies, or combinations, deliver the best outcomes for patients in a real-world setting.

It will improve patient access to digital survivorship resources such as Movember's True North initiative, which provides men and their families with treatment information and tailored lifestyle advice. This enables them to manage the physical and mental side effects of living with cancer, as well as the long-term side effects of treatment.

Last week, Movember announced a partnership with Montreal-based Electronic Data Capture (EDC) and registry software company Dacima to design and develop a new registry database.

The project will start with the Prostate Cancer Outcomes Registry – Australia and New Zealand (PCOR-ANZ) database. PCOR-ANZ, now in its fifth year of operation, already holds the details of 67,570 men and is aiming to identify population-wide trends in diagnosis and treatment. Movember-supported patient registries from other countries will soon join the network.

The competition of life

Changing how we think about what we're thinking or going through can have miraculous effects, writes Dr Troye Wallett.

Reframing is a powerful cognitive tool. Reframing is looking at an event or situation from another perspective, usually to approach it more positively. A simple reframe is adjusting language from 'I have to…' to 'I get to …'.

For example, changing your thinking from 'I have to drive my children 30 minutes to sports practice every week!' to 'I get to spend 30 minutes with my children, driving them to sports practice!'

James P Carse's book *Finite and Infinite Games* introduces the concept of finite and infinite games, which can be used as an idea to reframe events in our lives. This can be a useful and positive way of turning a thought pattern that is dragging us down into a power for good. It's advantageous to consider and understand the nature of the game being played.

A FINITE GAME HAS AN END AND A WINNER.

The Tour De France is a finite game. At the end of 21 days of racing, a winner stands on the podium and wins the biggest cycling event of the year. Finite games also have starts and finishes, winners and losers. They are played in an arena, sports field and cycling track.

Often we find ourselves framing our lives as a series of finite games, with a winner or an end point. But while some things in our lives are finite games, they are fewer than we think.

INFINITE GAMES ARE PLAYED FOR THE GAME.

Infinite games have no end, no winner, and are played for the sake of the game. A finite game turns into an infinite game when the timeline is changed. Investing in the stock market is a good example. Making money by trading over a year is challenging because the game has an end. You are either going to be up or down at the end of the year. However, over time, the trend of the stock market is up. By changing the timeframe over which the game is played, we reframe our understanding of success.

BUT LIFE *IS* A COMPETITION – ISN'T IT?

But life *is* a competition. It is survival of the fittest among Earth's limited resources. Some people have or gather more of these resources than others. Every job has multiple applicants, every dollar is hard-earned, and every race has one winner. How does this fit in with the concept of infinite versus finite games?

The Prisoner's Dilemma shows us how. It also demonstrates how cooperation beats competition in an infinite game because the rational decision changes if the situation is repeated.

The Prisoner's Dilemma is a thought experiment in which two thieves are caught and placed in separate rooms. Each is told: if you and your accomplice

are silent, both of you will spend one year in jail. However, if you confess and the other thief does not, you will go free and they will get three years in prison, and vice versa. If you both confess, you will both spend two years in jail.

Logically, if self-interest is paramount, the best strategy is to confess, because the results are either no time in jail or two years in jail, rather than one year or three years in jail if you remain silent. But it turns out that this only true if the game is played only once or is a finite game.

When it is played multiple times, it becomes an infinite game and becomes interesting. Played more than once, the winning strategy becomes a tit-for-tat with forgiveness becoming the conclusion. The best strategy becomes remaining silent at the start and then following the other prisoner's decision; if one confesses this time, the next time, the other confesses. Ultimately, though, the prisoners learn from the interaction and each will show some grace and return to remaining silent.

As an emotionless thought experiment, the best solution may be to confess. But overlaying a social element – with trustworthiness, compassion and loyalty adding value – the best outcome is to remain silent. Changing the dilemma from a finite to an infinite game fundamentally changes the best option.

The lesson that one can take from the Prisoner's Dilemma is to be compassionate and forgiving but not weak. But it only works when we choose to view life as an infinite game.

Other games can also give us an insight into reframing challenges in a way that can help us to deal with them – to compete more effectively, if you like.

AN INFINITE GAME SPORT

Ninja Warrior is a reality TV show in which men and women attempt to complete a challenging obstacle course. They are required to jump, climb, swing and balance their way through the course. It is the person versus the game. The wonderful thing about *Ninja Warrior* is that the athletes mainly compete against the course rather than solely against each other.

Ninja Warrior is an analogy for life. Success comes from a combination of talent, hard work, skill and luck. The course is hard and full of obstacles, but in the end, it is us versus life rather than us versus other people. Life is a competition in which success comes from cooperating and playing the long infinite game.

Reframing challenges in this way can help set us up for success. What game are you playing? How are you playing it? Is it a series of finite games or are you playing the long infinite game? Getting there first or with the most resources may seem like a good strategy, but that is not how you win the game of life.

A CHINESE FABLE

A farmer had only one horse. One day, his horse ran away.

His neighbour said, 'I'm so sorry. This is such bad news. You must be so upset.'

The man just said, 'We'll see.'

A few days later, his horse came back with 20 wild horses following. The man and his son corralled all 21 horses.

His neighbour said, 'Congratulations! This is such good news. You must be so happy!'

The man just said, 'We'll see.'

One of the wild horses kicked the man's only son, breaking both his legs.

His neighbour said, 'I'm so sorry. This is such bad news. You must be so upset.'

The man just said, 'We'll see.'

The country went to war, and every able-bodied young man was drafted to fight. The war was terrible and killed every young man, but the farmer's son was spared, since his broken legs prevented him from being drafted.

His neighbour said, 'Congratulations! This is such good news. You must be so happy!'

The man just said, 'We'll see.'

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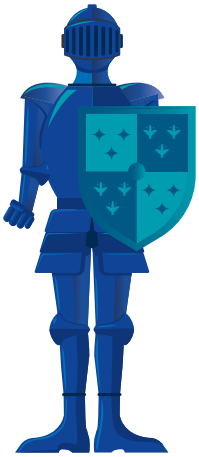
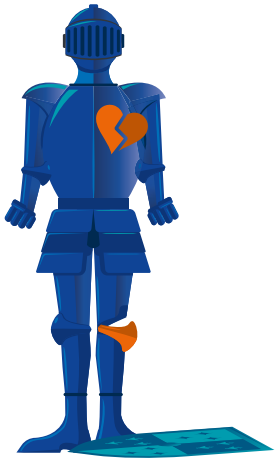
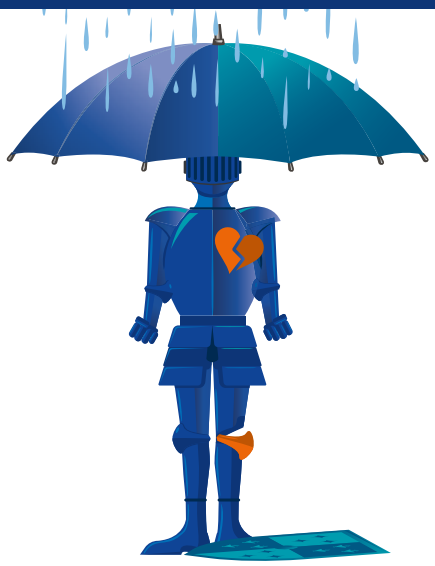


When we're young we tend to think we're unbreakable, bulletproof.



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



…that maybe it's time to get properly insured. **And with good reason** – especially when you consider the statistics below.

From the age of 35, insurance claims really start to soar.

In the last 5 years, TAL (one of Australia's largest life companies) paid:

To people up to 35	To people 35–46	To people 46–55
$66m	**$152m**	**$420m**

*Source: TAL

That's why we say to all our clients that it's better to get properly insured while you're still young and healthy – typically BEFORE you turn 35. Insurance is **much** more complicated than people think. That's why the DIY insurance path is so littered with disasters. And there's so much at stake….

It's time to get some professional advice – from an adviser with the technical expertise and experience required to make sure you're properly covered.

- Integrated protection plan
- The right mix at each life-stage
- Cost-efficient and tax-efficient structure
- Quality insurers at the right price

This is one of many insurance insights that enable us to help you protect your lifestyle and the people you love.

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

Spoilt for choice

Sports extras provide welcome a thrilling ride in BMW's MI35i, writes Dr Michelle Atchison.

Dr Atchison reviews the BMW M135i xdrive

I had the pleasure of driving and reviewing the new BMW M135i in April this year, largely thanks to Dr Robert Menz moving house and not being able to fit it into his schedule – thank you Robert for this opportunity! The car was supplied through Adelaide BMW on West Terrace.

The M135i is the third generation of the 1 Series, with the xDrive bringing the first BMW all-wheel-drive hatch to Australia. It also brings a change from their usual six cylinder turbo to a four-cylinder turbo engine producing 225kW and 450Nm, and boy what a ride it is for city driving!

The car I drove came with sports features including lowered M Sport suspension, M Sport brakes and 19-inch wheels. The body itself does not have 'wow' factor, but the interior is finished with sports inlays in the seats that wrap around you as if you are in a V8 race, and the panorama glass roof gives an extra-luxe feel. The digital key opens the door when you are close, and at night M insignias light up on the ground when you open the doors.

The eight-speed automatic has a number of driving styles, including a sport selection. I'm not sure I would recommend this for city driving, as the way it takes off in this selection pushes you back in your seat. You can choose your level of suspension comfort through these selections.

The car has an amazing array of safety features, including a head-up speed display, that is distracting at first and then very useful, shudder if you drift across a lane and the intelligent emergency call where BMW will call you through the car if it recognises you have been in an accident where airbags are deployed.

I drove the car for a week, during which it rained almost continuously. The car handled well with city driving except for the 'thrilling' take-off in sport mode. The comfort mode is better for city driving. In hills driving, the sport mode and the direct M Sport steering hug the road and give a feeling of immense safety on winding roads. The car has reversing assistance, a rear camera and park distance control front and back, making reverse parking an easy task.

The drive away price is around $75,000. I would thoroughly suggest taking a test drive.

The last pure allergist

Dr Allen Ewart Gale
MBBS, FACA

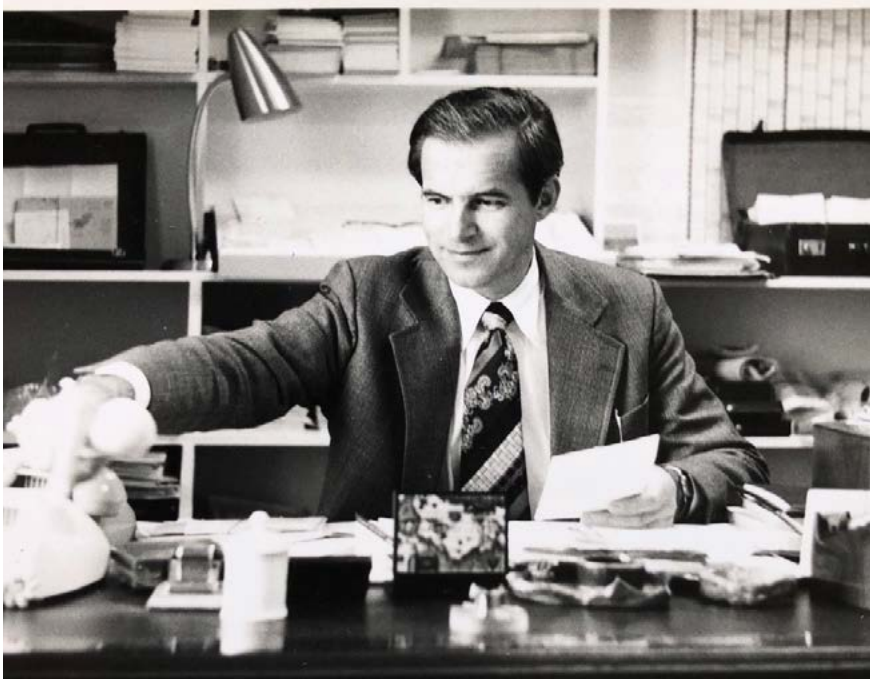
1932 – 2020

Dr Allen Gale engaged in allergy research

Allen Gale died recently and his funeral at St Peter's Cathedral was held on 26 June. He was born near Gladstone, South Australia in 1932 and finished his schooling at Prince Alfred College. He graduated with a MBBS in 1958 having to repeat final year due to glandular fever with severe hepatitis. He initially practised in rural general practice and then specialised in allergy. His hobbies were choir, violin and computing. He also developed a vineyard at Wilmington and was very involved with his grandchildren. He leaves a wife, three children, four grandchildren and two great grand-children. Allen is the last of the Adelaide cohort of pure allergists and was an active member of the Australian College of Allergists. He was involved with several national and international committees and societies in allergy and had a particular interest in aerobiology and aerosols. Indeed following on the earlier Adelaide studies performed by scientist Frank Mercer BSc in 1939, Allen with the expert assistance of Dr Sydney Birdseye and other Adelaide colleagues, conducted a five-year study (1969-74) correlating aero-spora abundance, environmental conditions and respiratory symptoms. Identified airborne pollens common on the Adelaide Plains included local grasses, Plantain, Chenopods, Cypress, Ash, Plane, Elm, Pine, Wattle, Olive, Salvation Jane, She-Oak and various moulds. Regular daily pollen counting continued with the establishment of the Adelaide Aerobiology Laboratory and Allen provided a daily pollen count to Asthma SA until his retirement on 2018.

In 1981 Dr Gale became Head of the Paediatric Allergy Unit at the Adelaide Children's Hospital. He was ably assisted by Dr Francis Mocatta, who had an appointment as visiting allergist. He introduced Dr Billy Tao and Dr Robert Heddle to specialised private allergy practice. Allen brought nebulised Ventolin to asthmatic children in the ACH emergency room that was a major advance in management.

His roles included Past President, International Society for Aerosols in Medicine, Memberships of the Editorial Board International Journal of Biometeorology, Australasian Society of Clinical Immunology and Allergy, the European Academy of Allergy and Clinical Immunology and the New York Academy of Sciences. He held visiting appointments at most Adelaide teaching hospitals and was a life member of the Asthma Foundation SA and the Adelaide Children's Hospital.



Dr Allen Gale as a busy young doctor

Dr Bob Heddle and
Dr Peter Roberts-Thomson

Accepting no limits

Dr Di Cox
MB BS, FRACGP, Dip Obst.

1951 - 2020

Dr Di Cox

Diana Margaret Cox (Di) was born in Liverpool in the United Kingdom (UK) where her father Lloyd Cox was completing his post graduate studies in Obstetrics and Gynaecology (O&G). The family returned to Dunedin in 1952 where her father worked as an obstetrician until 1958 when he and the family moved to Adelaide as he had been appointed as the foundation Chair of O&G at Adelaide University.

In 1969 Di enrolled in Medicine at Adelaide University and over the next six years made very many close, lifelong friends.

Di did well academically but not at the expense of social interaction. She was active in the university water-ski club, organised snow ski and houseboat trips, and was a regular at medical dinners and balls.

Graduating at the end of 1974, she moved to Auckland where she completed her intern year before a brief stint at the St George hospital in Sydney.

She then – boldly for a time with no phones or internet with which to keep in touch with family and friends – undertook a solo trip through Southeast Asia and the Middle East on her way to the UK where she gained a Diploma of Obstetrics before returning to Adelaide. She gained her Fellowship of the Royal Australian College of General Practitioners (FRACGP), and joined a general practice in Woodville close to the Queen Elizabeth Hospital (QEH) and she was appointed a senior visiting specialist in the department of O&G at the QEH where she worked in the ante-natal clinic.

During her working life, Di put her leadership skills and enthusiasm to good use becoming an examiner for the RACGP and she helped set up the South Australian Shared Care obstetric program.

She was a passionate advocate for women's health and represented the College of GPs on a large number of committees and task forces concerned with cervical screening, shared care obstetrics and maternal and perinatal mortality.

In 1996 she joined a general practice in Blackwood where she was much loved by her patients and fellow practitioners and where she worked until her retirement.

Throughout her busy professional life, Di was an active committee member of the Australasian Medical Graduates for Further Education (AMGFE), which ran annual eclectic medical meetings in the ski fields and she was a driving force within her medical class reunion committee.

While skiing in Colorado in 2012, Di experienced what she thought was an exacerbation of asthma triggered by the high altitude. On returning to Adelaide, investigations told another story – that she was suffering from idiopathic pulmonary fibrosis (IPF), a condition of unknown aetiology with no known treatment and a mean survival of just three years post diagnosis.

Di's initial reaction was disbelief. She was a strong believer in preventative medicine, encouraging her patients to exercise and eat sensibly – a mantra she practised herself.

She determined not to give up but to adapt her lifestyle to the limits imposed by her condition. There were no more trips to the snow, these being replaced by camping and walking trips with her husband Max throughout Australia.

She developed a passion for the Australian Wildlife Conservancy, a group devoted to the preservation of endangered wildlife and their habitats. She took up painting and continued playing golf, resisting using a cart until she could no longer walk the course.

Although acknowledging that it was unlikely to help her, she made a generous donation to Lung Foundation Australia to establish the Diana Cox PhD Scholarship in IPF research.

Last November was the 45th anniversary of our graduation from Medical School and, despite her deteriorating health, Di worked tirelessly to organise a hugely successful function. Not many at that function knew of her condition and only a very few of us knew just how much her pulmonary function had deteriorated and how close she was to needing a transplant.

Due to the travel restrictions of COVID-19, Di and Max moved to Melbourne earlier this year in case a donor became available. Sadly, she passed away on 10 July 2020 before this was possible.

Using the database Di had painstakingly assembled, our classmates were informed of her death via a group email. Most replied with tributes and condolences, commenting on her vibrant and dynamic personality, and many described her as the anchor of our cohort. The most poignant comment came from one of her very many close friends who commented 'I have nothing to add but tears'.

Di is survived by her loving husband, Max Klubal, brother David, nephews Samuel and Alexander, and cousin Margaret Blackmore.

She will be sadly missed.

Dr Glen Benveniste

Extensive influence

Dr John David Richards
MBBS, FANZCA

1932 – 2020

Dr John Richards

John Richards was born in Broken Hill in 1945 into a medical household. His father was a general practitioner in Broken Hill and his mother was in charge of obstetrics at the Broken Hill hospital.

Like many from Broken Hill, though, John spent his school days in Adelaide. Both his primary and secondary education were at Pulteney Grammar School in Adelaide. Following the family career path, John commenced medical studies at the University of Adelaide in 1964 and he graduated in 1970. After his compulsory residency year at the Royal Adelaide Hospital, he spent a second year at the Queen Elizabeth Hospital that included a term of anaesthesia and he was invited to undertake the anaesthetic training course which he completed in 1975.

Following this, he was invited to join one of the private anaesthetic groups in Adelaide, Adelaide Anaesthetic Services, where he remained a highly valued member until his retirement in 2014.

John built a reputation as an excellent anaesthetist, always willing to do extra work when required at any time of the day or night. True to the old adage: if you want a job done, give it to a busy person, John attracted additional responsibilities. Despite the heavy workload, he found time to be on various committees and medically orientated groups, including the South Australian branch of the Australian Society of Anaesthetists (ASA), where he became chair. He joined the federal committee of the ASA, serving as its president from 1990 to 1992.

John was also actively involved in the medical profession more broadly, serving on the committee of the AMA(SA). He helped form the Pacific Society of Anaesthetists and was on the committee of the Asian Australasian Regional Section of the World Federation for eight years; this involved travelling to Burma, India, Pakistan, Taiwan, Fiji, Malaysia, Thailand and Sri Lanka.

Dr John Richards with his wife, Etelka

Before his death, John was in the process of helping fellow anaesthetists David Fenwick, Anthony Swaine and Bruce Perks (and others), write a book on the history of anaesthesia in South Australia, contributing a huge amount of research.

Like many busy people, John was also a social organiser and he helped coordinate activities for his medical school group with great success and enthusiasm.

I was fortunate to be a member of Adelaide Anaesthetic Services at the same time as John and his contribution to that group was enormous. He seemed to have endless energy and a wonderful personality to go with it.

Outside of work, his main interests were reading, making model boats and ships of all shapes and sizes, as well as wood carving. Several of his major works have pride of place in his home.

He also built a beautiful conservatory onto his home. There was, however, a small problem with this project that became legendary. He managed to enclose a trailer within it and had to partly dismantle the building to remove the trailer.

John was an A-grade squash player until his workload intervened. He loved sailing in his earlier years, and later this evolved into a love of motorboats of all sizes that he operated with great enthusiasm until ill-health interrupted.

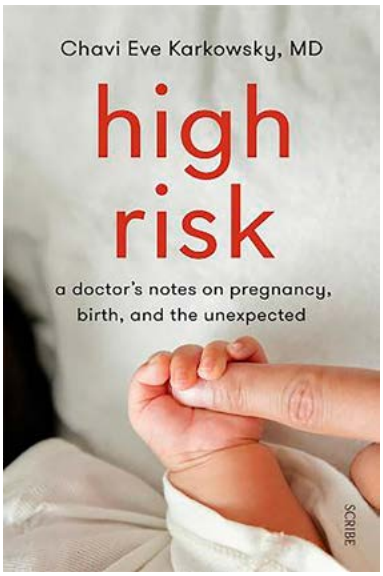
John was a very dear friend and colleague and will be sadly missed by the many people who knew him.

He is survived by his wife, Etelka, and two sons with their families, including five grandchildren. John and Etelka were married while John was in the fifth year of his medical degree. She was an incredible support during John's battle with some very unpleasant illnesses and treatment.

Dr John McEwin

High expectations

AMA(SA) Editorial Committee member and retired obstetrician Dr Melissa Sandercock finds much to think about in a New York colleague's ruminations about her career.



High risk - a doctor's notes on pregnancy, birth, and the unexpected

by Dr Chavi Eve Karkowsky

Scribe Publications, 2020

Dr Chavi Eve Karkowsky is a maternal-fetal medicine specialist in New York City and therefore has ample experience in the area of women's health and provision of services for maternity and gynaecology care.

This is Dr Karkowsky's first book, although she is well known for her contributions to *The Daily Beast*, *The Atlantic*, *Health Magazine*, *Slate* and *The Washington Post*. She says she wrote this book because she believes she has 'the most interesting job in the world'.

'Once I was involved in medicine,' she writes, 'I was immediately addicted to the action (though I still love to talk). I wanted to be part of the muchness of it, the everyday drama and blood and terror and joy.'

Divided into sections on the three trimesters of pregnancy, term pregnancy, hospital and out of hospital care and postpartum, the book pulls case histories, personal experience and the politics of women's health into insightful commentary. Some comments relate to professional training and how poorly it trains us doctors to manage the raw emotions of our patients and ourselves as we deal with ethical decisions, life and death. Others consider the inadequacies of the system within which Dr Karkowsky works. Fortunately, our system in Australia is a little different to, and has better access to care for all, than the US one the author knows.

Dr Karkowsky also addresses those issues that make obstetrics, in particular, different in terms of patient expectations and therefore more difficult for doctors to communicate with women who do not speak their medical language. In her introduction she writes, 'This lack of nuance and depth is a problem for all medical fields, but I do think it's an especially difficult problem with respect to pregnancy and pregnancy complications … We have expectations of pregnancy that we don't have of other medical experiences.

'We expect a pregnancy and its outcome to make us happy and to complete us; we don't have such expectations from an appendectomy or a bone scan.'

Dr Karkowsky is a passionate advocate for women and their right to have control over their bodies, their reproductive rights and their rights to access care and support. There is implicit bias and there are significant barriers to access on racial, disability and socioeconomic grounds in the US, some of which translate to our Australian environment. I found particularly interesting her thoughts on maternal mortality and its effects on the staff and culture of an institution, and those relating to informed consent and particularly the proposal for consent to be given/taken for labour and delivery.

'To me, that's the worst and most paternalistic aspect of offering "consent" for labor and delivery,' she writes. 'Signing consent for something your body does, a function your body performs, is pretending that natural labor is something that someone else *does* to you.

'It is pretending that someone else is in charge. It is the relinquishing of agency over your own body and what it is doing - agency that women have fought years to establish.'

I enjoyed reading this book and identified strongly with the emotional, ethical and clinical dilemmas presented. I think it would appeal to anyone working in women's health but equally anyone curious as to the resilience of those who work in the area. I would strongly recommend it to my colleagues, doctors in obstetrics and gynaecology (O&G) training and others considering O&G as a career.

Melissa Sandercock
BMBS, FRANZCOG (ret)

WE'RE HERE FOR YOU

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

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

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

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

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

Phone: 8361 0100

The next meeting of the AMA(SA) Council will be held on Thursday, 5 November 2020.
Any member wishing to attend the meeting should contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au.

DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

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

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

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

DOWNLOADING YOUR TAX RECEIPT

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

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

To access your tax invoice:

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

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

ACCESSING THE AMA FEES LIST

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

NOTICES

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

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

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

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

Neurosurgeon Dr Cindy Molloy would like to thank you for your support and referrals over the many years that she has consulted in Adelaide. She wishes to advise that she has now retired from private practice. Current patients are being notified by the rooms.

Dr Sam Boase BMBS (Hons), PhD, FRACS, ENT, Head & Neck Surgeon, welcomes your adult and paediatric ENT referrals. Dr Boase consults at Adelaide & Hills ENT situated at 191 Wakefield Street, Adelaide. T. 08 8185 1661; ahent.com.au

Dr Xenia Doorenbosch MBBS, FRACS, Neurosurgeon wishes to advice that she is available for private adult referrals. Dr Doorenbosch has an interest in the management of brain tumours and hydrocephalus and consults at the Memorial Medical Centre, 1 Kermode Street, North Adelaide. T. 08 7127 2298; drxenia.com.au

Dr James Badlani BDSc, MBBS, FRACDS, Oral & Maxillofacial and Head & Neck Surgeon wishes to advise he has commenced in private practice. As well as his public appointment at the Royal Adelaide Hospital, he is involved in training programs in oral & maxillofacial surgery, and head & neck microvascular surgery. Areas of interest include oral cancer, head & neck skin cancers, salivary gland pathology, thyroid surgery, and microvascular reconstruction.

Dr Badlani consults at both Krishnan Medical Centre, 4/42 Commercial Street, Salisbury, and 285 Wakefield Street, Adelaide. T. 08 8258 1143; drjamesbadlani.com.au

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