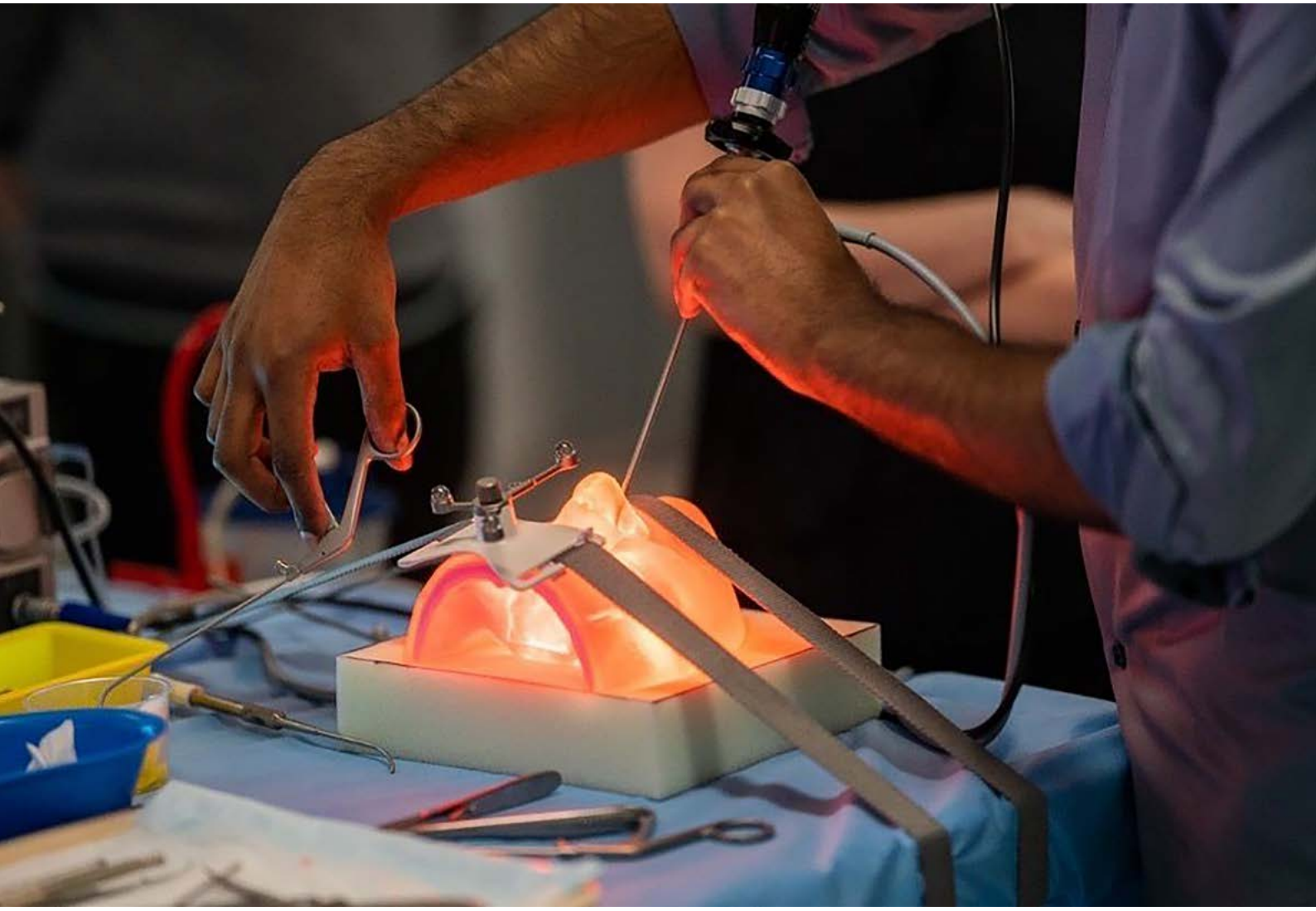
medicSA
APRIL 2021
VOLUME 34 NUMBER 2



Role models

The South Australian team revolutionising surgery training

AMA SOUTH AUSTRALIA

2020 HOSPITAL HEALTH CHECK RESULTS • 12 MONTHS IN PANDEMIC MODE
HONOURING OUR NEWEST LIFE MEMBERS • ABORTION AND ADVOCACY

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Production
Typeset and printed for the AMA(SA) by Douglas Press Pty Ltd.
ISSN 1447-9255 (Print)
ISSN 2209-0096 (Digital)

Cover artwork
Photo supplied by Fusetec.

Contents

In the early months of 2020, WA surgeon Dr Omar Khorshid and AMA(SA) President and GP Dr Chris Moy decided they would run for election as the Federal AMA's president and vice-president respectively. They campaigned and, in elections staged in August, they won. But in all the months of planning and lobbying, and in the eight months since, they did not meet in person once. With COVID-19 restrictions limiting travel and dominating work schedules, it took Dr Khorshid's visit to South Australia in mid-April for them to sit in the same room together.

President's report

Dr Chris Moy

It only seems like yesterday when I stood on the stage at the 2019 AMA(SA) Gala Dinner and received the President's medal from my predecessor as President, Associate Professor William Tam. But it has been almost two years, and this will be the last *medicSA* that will be published with me at the helm.

For AMA(SA), so much has happened during this time. We appointed CEO Dr Samantha Mead after Dr John Woodall came to our rescue to act in this position in early 2019. We've farewelled staff members and welcomed new ones. AMA House has been rendered uninhabitable by first fire and then flood.

Despite all this, there has been energy and influence during this period. Our Doctors in Training, General Practice and Road Safety committees have bloomed again under the leadership of Drs Hannah Szewczyk, Bridget Sawyer and Bill Heddle respectively. We helped support individuals and communities recover from devastating bushfires in our state and across the nation. We staged a Culture and Bullying Summit that led to tangible changes in South Australia policy and law – most notably with amendments to the Health Care (Governance) Amendment Bill 2020 now making it clear that Local Health Network Boards are directly responsible for the culture, and impacts of this culture, on their staff. The AMA(SA) was respectful but unequivocal in prosecuting existing AMA policy that abortion is a women's health issue, and played a central role in the passage of the Termination of Pregnancy Bill 2020 that finally lifted the anachronistic burden of criminality from women already faced with distressing decisions.

And, of course, there was a pandemic. My presidency was eight months old when made my first public comments about the virus; 15 months later, still no one can predict how long it will continue to affect our health, our lives, our society and, of course, our health system. In this issue of *medicSA*, AMA(SA) Councillors Dr Peter Subramaniam and Dr Danny Byrne, and Chair of the Australian Society of Anaesthetists Dr Brigid Brown, give some perspective on life as we now know it – but of course each of us has experienced this strange and anxiety-provoking time differently. We have been so fortunate to live and work in a country where, because most people have been happy to listen to the science, we have to date evaded much of the death and destruction that has been seen overseas. With a shift in focus to the vaccine rollout, I do hope that it's not too long before my successor can write about life in a 'post-COVID' world. Whenever this happens, I will leave with satisfaction in knowing that the AMA – as an organisation but most importantly as members – really did stand up when the chips were down for our community and our patients.

Through all of this, and for many years beforehand, Dr Phil Harding has been bringing his experience, humour and, most importantly, his love to the management and pages of this magazine. On behalf of the AMA(SA) Council and Board, I would like to publicly thank Phil for his service to the AMA. Phil, we wish you well. You are simply a legend, and we will recognise your contribution more appropriately in the June edition.

As I approach the appointment of a new AMA(SA) President at the AGM on 6 May, I'd like to thank all those who have supported me during my term – most importantly my wife and my family, whose patience and sacrifice have helped keep me somewhat on the path of sanity. To Vice President Dr Michelle Atchison, Dr John Nelson, and all members who have served on Council and the Board during this period; Dr Mead; Senior Policy, Media and Communications Advisor Karen Phillips; and, of course, our much-loved Executive Assistant Mrs Claudia Baccanello: I bow to you all with thanks in my heart. I won't be going away quite yet – I am national VP for another year! But I am looking forward to watching our AMA(SA) turning the page onto its next chapter, and seeing it continue its invaluable work for members and the community from a different perch. In the meantime, if you can bear listening to me speak one more time, please consider joining us at the Gala Dinner on 22 May; details are on page 13. We couldn't stage a dinner last year; this will be a fantastic opportunity to gather and remind each other why we do what we do.

What is it that will give me greatest satisfaction when I look back at my time as President? Well, my hope is that my time will be remembered as one in which the younger members of our profession – our medical students and junior doctors – learnt the value of leadership, so they will want to become leaders of our profession in the future. In regarding myself as somewhat of an accidental leader (who also happened to cop a pandemic during his watch!), I now have a deep understanding that leadership matters. Not leadership for the sake of it, but leadership that is understood to be service, is founded upon genuine ideals, and is done with a smile. It is said that 'decisions get made by people that turn up'. For the sake of our patients, but also to guard all the values that make us want to become doctors in the first place, I hope that and pray that we, as members, continue to turn up.

Editor's letter

Dr Philip Harding

The time comes on life's journey when the road curves and it is time to take another path. That time has come for me, to place a full stop on my period as editor of *medicSA*, a role I first took on in 1989.

As some of you may remember, I've actually been editor twice. It is a privilege that has given me insights into the achievements and challenges of our profession, many of which continue now.

Looking back on the road travelled, some issues and events have been personally significant.

The country hospital crisis, where AMA(SA) strongly supported increased funding and restructuring of country services, made me aware of the importance of membership numbers and of the interaction between medico-political bodies, the government and the community.

The student mentoring scheme was another one. It was developed to meet the needs of students and young practitioners at the point of career choices. I served my internship at the Royal Adelaide Hospital (RAH), where one person above all inspired us students. Senior physician Dr Mark Bonnin had such a tremendous breadth of knowledge and enthusiasm. He lived for medicine, and he taught by example.

During my tenure as editor, there may have been times when I was told to 'get off my bike', when I was demanding copy by a certain date. As a bike rider, I am proud that AMA(SA) was involved in the development of 'The Cycling Strategy for South Australians'. The committee was external and chaired by then-Transport Minister Di Laidlaw, and I believe indicates our focus on a healthy environment and lifestyle for our patients.

I believe in the benefits of a strong partnership between medicine and the media. Early in my two years as President (1990-92), we were able to organise an interview on Channel Nine's *Adelaide Today* television show. AMA(SA) Vice-President Dr Jill Maxwell spoke about the function and aims of our organisation. Today, in 'covid' times, the media has helped ensure that the public has seen clearly the AMA's significant role in public education.

Dr Phil Harding and Mrs Margie Harding with AMA(SA) President Dr Chris Moy

Dr Phil Harding and Mrs Margie Harding at their Kent Town home

I could not conclude without mentioning the 1992 AMA Golf Day. Convened by Dr Glen Beneviste, the Golf Day attracted about 120 players who defied sweltering conditions and compete for a magnificent range of prizes, and then indulged in a splendid dinner. Sadly, your retiring editor was not one of the prize winners!

To the people who have worked with me over all the years I've been in this position, I tender my affection and my respect. And in meeting this last deadline, I say 'thank you', for your help and support.

Best wishes to my friends and colleagues; doctors past, present and future. Continue the good fight!

New medical editor for *medicSA*

Doctors Health SA medical director Dr Roger Sexton is the new medical editor of *medicSA*.

Dr Sexton has worked for over 35 years as a rural procedural GP in Mount Pleasant and across the state as a rural locum. He was the last Presiding Member of the Medical Board of South Australia and has been the medical director of the Doctors Health SA (DHSA) program since 2010.

Dr Sexton's other previous roles include coordinator of GP training at the Queen Elizabeth Hospital, clinical skills tutor at the Adelaide Medical School, and South Australian representative on the Federal AMA Council of General Practice. He is currently Deputy Chair of MIGA and member of the boards of GPEx, the Barossa Hills Fleurieu Local Health Network and Doctors Health Services.

Dr Sexton's clinical work includes executive health, rural council skin cancer screening and the DHSA doctors' health program.

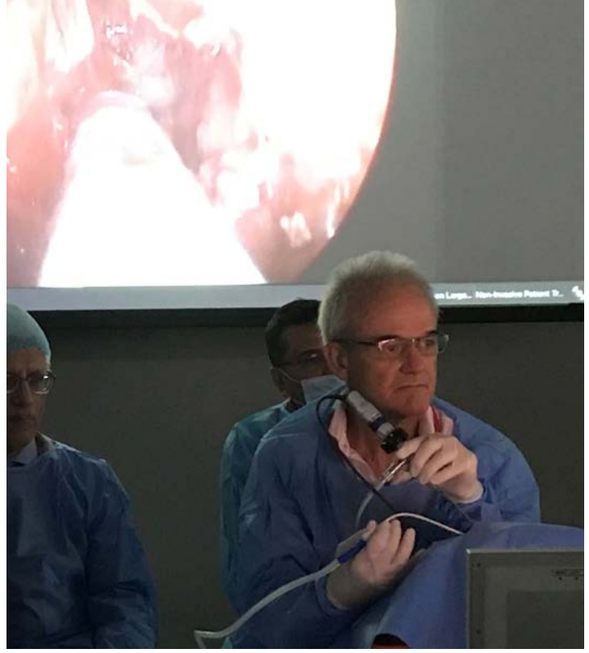
After studying medicine at the University of Adelaide, Dr Sexton completed his MBA at the University of Adelaide and University of Glasgow in 2015. He received the AMA(SA) Medical Educators award in the same year.

Dr Sexton says he has 'big shoes to fill' in following Dr Phil Harding, who is stepping down as medicSA's medical editor this month. 'Under Phil's guidance, the magazine has long been a valuable way of celebrating the outstanding contributions by the medical profession to the health of the community,' he says.

Model of care

An Adelaide Medical School surgical training team and its entrepreneurial partner are on the verge of revolutionising surgical training.

Professor Peter-John Wormald removing a tumour on a Fusetec model



Professor Wormald at Mohammed Bin Rashid University in Dubai

Fusetec's Mark Roe observing at King Saad University, Saudi Arabia, pre-COVID

World-first online sinus surgery training introduced due to pandemic travel restrictions could transform the way all surgeons are taught and trained, according to the Adelaide surgeon whose team developed the remote course.

In February 2021, the Adelaide Medical School's Professor Peter-John Wormald and Professor Alkis Psaltis, and Japanese surgical colleague Dr Masanobu Suzuki, together trained surgeons through simulations performed at Hokkaido University in Japan, while more than 200 surgeons from around the world observed.

Prof Wormald and Prof Psaltis convene an advanced sinus surgical workshop at the Adelaide Medical School's Ray Last Anatomical Department each year.

Dr Wormald says having to quickly respond to pandemic-related international travel restrictions and the recent availability of lifelike 3D advanced manufactured models and Quintree software enabled the team to develop and deliver online training that otherwise may not have been possible for several years.

Three surgical residents in Japan performed the same endoscopic procedure on 3D models created by Adelaide company Fusetec, while others across South-East Asia watched online. At the same time, Prof Wormald and Prof Psaltis supervised from their Adelaide lab as each surgeon performed the procedure on the 3D model, and gave feedback translated into Japanese by Dr Suzuki – himself an experienced surgeon who has trained in Adelaide.

Professor Wormald is excited about what he sees as potentially transformational change to surgery training. He says the online delivery and use of the models will take surgical training to a level similar to that of aviation, where simulation software and cockpits can train pilots to overcome the most complex issues without leaving the ground.

He says the anatomy of the models is identical to that of humans as they manufactured using the digital images of patients' CT sinus scans, and the polymer material is very similar to human tissue.

Students performing surgery on the Fusetec model

'For the first time, we can create standardised, repeatable training tasks that all trainees can be required to complete on the same model, with the same anatomical structure and same abnormality or pathology, with exactly the same degree of difficulty, within the same circumstances,' Prof Wormald says.

'That has enormous implications for surgical training. Until now, surgical training has been on patients supervised by consultants – now training and examinations can be conducted with each trainee presented with the exact same conditions.

'There's also the capacity to categorise procedures according to degrees of difficulty, so that trainees can be asked to reach certain standards at one level before they advance to more complex procedures.'

Prof Wormald and Prof Psaltis usually convene an advanced sinus surgical workshop at the Adelaide Medical School's Ray Last Anatomical Department each year. They planned to conduct the course with the newly available 3D models in person last year, repeating the success of a Functional Endoscopic Sinus Surgery (FESS) course in November 2019, when 80 attending surgeons dissected 160 Fusetec models. However, the 2020 FESS course was postponed due to the pandemic.

'COVID forced us to investigate online alternatives to traditional training methods,' Prof Wormald says.

'We looked at Zoom, but that didn't allow us to involve enough people simultaneously. Quintree enabled us to use secure video links to supervise and comment on the work of each surgeon, all at the same time, and also allowed others to watch the operations from across Asia or anywhere in the world.'

He says the team is now receiving requests for similar course delivery from Russia, the US and Europe.

'The biggest issue is the time difference,' he says. It's not such a problem in South-East Asia, but with each course taking several hours it is something we need to work out for training in the UK, for example.'

Prof Wormald says the quality of the 3D models was a 'game changer'. There are nine models available, with 18 different anatomical structures – each one based on a real patient that the Adelaide team has operated on.

'Fusetec invested more than $8 million in digital technology,' he says. 'They're now able to introduce the layers of complexity and the delicacy that surgeons face in the operating theatre.

'We can almost entirely mimic the situation that occurs when you operate. We have the complex anatomical structure based on actual patients' sinuses. The surgeons can operate on the model, we can then demonstrate the surgery, and finally for reinforcement we show the real operation in a video taken during that patient's actual surgery.

'When we can even make them bleed, it will change training entirely.'

But blood isn't far away, says Fusetec's Adelaide-based CEO Mark Roe. Mark, who described himself as 'an entrepreneur looking for a problem to solve' – has been working with Prof Wormald throughout the development of the 3D advanced manufactured polymer models. Together, they have now developed technology to add 'blood and a pulse' to the models, and to the complexity of the training modules, with products to be launched within a few months.

'We're at the final stages of prototyping models that will have blood pumping through main arteries, with a pulse,' Mr Roe says.

'This means that in the training sessions, PJ (Prof Wormald) can nick the artery on purpose and teach trainees how to stop the bleeding. It adds another layer to the technology we've developed here in Adelaide, which is attracting million-dollar orders from multinational medical device companies.

'We started with ENT, and now we're developing models for neurology, gynaecology, cardiology, orthopaedics, general surgery and anaesthetics. The plan is to keep developing the models, with varying anatomical complexity, so surgeons can be trained without risk to themselves or their patients.

'It's all about upskilling residents and advancing surgeons' skills that will ultimately save lives.'

Dr Wormald says the range of models already available provides much-needed diversity for surgical trainees.

'When you've done 18 of these complex surgeries, it's pretty good training,' he says. 'We're presenting trainees with more complex cases than they would see when operating on cadavers, most of which have no complex sinus issues at all – in one traditional FESS course of 20 cadavers, you may have one or two with complex anatomy, and no two surgeons would be operating on the same anatomy.'

While Professor Wormald is excited about the potential for surgical training, he's not expecting the models to be accepted overnight. He says even the lower cost – at about US$250 for one of the 3D models compared to thousands for a cadaver – won't be enough to convince his colleagues.

'Cadavers have been used for medical training since the 1500s,' he says. 'Surgeons take a long time to adopt anything new, and in some ways that's a good thing,

'We're now faced with something that could revolutionise surgical training, but it will take some time to filter through and convince surgeons that this is a better way to do what's been done for centuries.'

Mr Roe understands the caution. 'Surgeons have been looking for alternative training models for decades but have a healthy fear of change,' he says.

'The models have many distinct advantages, like pathology on demand and no harmful bacteria, which in turn means no wet labs or sterilisation are required.

'I'm confident these advantages will eventually change how we train surgeons.'

Advocacy matters

AMA members' voices and knowledge were critical in bringing in the long-overdue changes to South Australia's abortion law, writes maternal health expert Associate Professor Rosalie Grivell.

Dr Chris Moy and maternal foetal medicine specialist Associate Professor Rosalie Grivell (centre and second from right) with (from left) Michelle Lensink MLC, Attorney General Vickie Chapman and Professor Katina D'Onise, Executive Director, Prevention and Population Health, Wellbeing SA

As an intern in 1999, I decided I wanted a career in women's health. Passionate about an area of medicine that seemed the perfect mix of counselling, diagnostics, prevention through early intervention, and continuity of care, I completed my training in obstetrics and gynaecology a decade later. I couldn't have known at any step along this career path that I would be in the right place at the right time to influence legislation that will have an effect on thousands of women's lives.

After months of lobbying, the Termination of Pregnancy Bill 2020 finally passed in the Lower House in the early hours of 19 February. It is not exaggerating to say it would not have passed in its current form without the contributions and interventions of AMA(SA) President Dr Chris Moy – interventions that continued until the final minutes of debate, as politicians messaged him to gain his thoughts on one amendment after another.

In the weeks leading to the vote, I stood with Chris, and with politicians such as Attorney-General Vickie Chapman and Bill proponent and Minister for Human Services Michelle Lensink MLC, to explain to members of parliament what the proposed legislation would mean; what it would change. We wrote fact sheets and letters, and attended briefings, explaining in detail the processes involved in seeking advice about and obtaining terminations, the AMA position on conscientious objection, and the levels of protection that govern practitioners' decision-making. One of the letters was sent urgently to all MPs on 17 February, as it appeared possible that proposed amendments would thwart the reform, or make AMA support impossible for any Bill that did pass, or both.

We entered rooms of people – intelligent and highly educated people – who may or may not have read any or all of the 560-page South Australian Law Reform Institute report that recommended decriminalisation, among other legal changes; who may have had strong views for or against abortion because of personal beliefs or faith, or because of their perception of electorate views, or for other reasons; who may have many competing agendas as they contemplated their vote on any issue, and especially one of 'conscience'.

As a clinician and researcher, I am accustomed to presenting data, research, evidence. But in these rooms, I found, evidence could so easily be pushed aside as politicians considered an emotional story. More infuriating, these educated people would raise hypotheticals that clearly demonstrated they have no confidence in women and their decision-making capacity. 'What if a woman's partner leaves her when she's 30 weeks pregnant and she decides she doesn't want the baby?' was one question posed. And so much discussion hinged on participants' tightly held concepts of traditional family and a woman's role in it. So many times, we were forced to emphasise the need to trust women with their bodies and their supports and their definitions of family, and that these decisions are simply about listening to and believing women.

Such hypotheticals, and the amendments being considered because of such thinking, denigrate women. But they also suggest that these politicians don't trust us doctors, our knowledge, or our decision-making processes. Time and again, the intense debate over late-term abortions included phrases such as 'abortion up to birth', as if decriminalisation would increase both the number of such terminations and the willingness of doctors to perform them. It didn't matter how many times we tried explaining that by specifying how to avoid gender selection in legislation, there was a risk of creating perverse results and complexities, the parliamentarians would not drop the subject. It was clear the Bill would not pass without a provision to address their (unfounded) fears.

Advocacy isn't a 'skill set' many of us learnt specifically as doctors. We learn about the importance of communicating with patients and their families, support people. Some of us are better at it than others. But we don't learn how to advocate for our patients and their care in a broader sense, so that we influence social change and make a difference on a macro level; we must either choose to learn this, or pick it up when the occasion requires.

I think of doctors speaking so loudly for our environment and to limit the impacts of climate change; they have found ways to use their voices to make a difference, but most of us don't.

I needed to learn how to speak to these non-medical groups, try and guess what they might be thinking and why, and to use my facts and knowledge to help them understand when and why women seek abortions, how and where doctors and other health practitioners support them, and what the state's legislation should include to provide for abortion as a women's health issue. I was 'the expert', and was able to use my voice and my experience in a way that was really meaningful.

I also saw the importance of partnerships: those involved in this support and advocacy spanned disciplines and professions. One of the strengths of the group of people who stood together, met with MPs, rallied on the steps of parliament and also mounted social media campaigns was the interdisciplinary focus. Doctors stood with midwives and nurses, lawyers and academics, patients and family members. Together we were stronger than we could possibly have been as individuals or sector-based lobbyists.

And I saw firsthand the importance of the AMA, and leaders who have chosen to make their voices heard – not just for their patients, but for communities. Sometimes, the voices are quieter, advocating and contributing to change behind the scenes, away from the headlines. Sometimes, they must be loud.

This was a fantastic win.

Associate Professor Rosalie Grivell is a maternal foetal subspecialist at Flinders University and chair of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (SA/NT).

The Termination of Pregnancy Bill that passed the Lower House in February includes the following important criteria:

- Removal of the threat of criminal action for pregnant women and doctors
- One practitioner for most decisions (until 22 weeks and six days)
- No criteria regarding residency of the woman
- Insertion of 'medically appropriate' criteria
- A practitioner who has a conscientious objection needs to either refer the patient to, or provide information about, another health practitioner or service that can provide the care
- A specific 'ban' on sex selection
- A requirement for women to be provided with information/counselling.

Dinner party

After the pandemic forced its cancellation last year, the AMA(SA) Gala Dinner will be staged again in 2021.

Award-winning journalist and best-selling author Leigh Sales will be the guest speaker at the 2021 AMA(SA) Gala Dinner on 22 May.

Last year, the annual celebration was – like so many social events in 2020 – cancelled due to pandemic restrictions. AMA(SA) CEO Dr Samantha Mead says the pandemic has also led to a change of format for this year's Gala Dinner, with any plans for a stage performance involving many people 'both unappealing and risky'.

'After the cancellation of so many events last year, we really wanted to stage an event that would bring together so many of our members, colleagues, partners and friends,' Dr Mead says.

'At the same time, we are aware of the volatile nature of the COVID-19 environment, which could alter plans at any moment. We decided that a prestigious dinner with a high-profile guest speaker was the best option for our members at this time.'

Dr Mead is looking forward to an event that will be the 'public swansong' for Dr Chris Moy in his role as President of AMA(SA). Dr Moy's successor will be decided at the AMA(SA) Annual General Meeting on 6 May, 16 days before being presented to members and guests at the Gala Dinner.

'We know from the comments we've received from members, other doctors and health practitioners and the public that Chris has been an outstanding president in a unique period,' Dr Mead says. 'We urge members to join us at the dinner to thank him for his incredible service.'

EXTRAORDINARY COVERAGE

Ms Sales has been the presenter of the ABC's flagship *7.30 Report* program for a decade, taking over after the retirement of long-time anchor Kerry O'Brien. Like Mr O'Brien, Ms Sales has become a household name for her interviews with prime ministers, visiting dignitaries and celebrities.

With degrees in international relations and journalism, she was the ABC's national security correspondent from 2006 to 2008. As Washington correspondent from 2001 to 2005, she was in the US to report on the nation's response to and recovery from the September 11 terrorist attacks.

She won a Walkley Award – Australia's highest award for an individual journalist – in 2005 for her coverage of issues surrounding Guantanamo Bay and was also nominated for her on-the-ground reporting of Hurricane Katrina.

Her profile has also led to her being a target of online abuse, as she highlighted on Twitter in July 2020. Ms Sales tweeted that the examples she shared on Twitter – with 'rude b----h' possibly the least offensive – represented just 'a fraction of the sexualised abuse' she receives when she interviews the Prime Minister. She wrote at the time – long before the recent, high-profile issues confronting the government related to its consideration of women – that 'female politicians, journalists, public figures get this non stop'.

In the months since, she has been criticised for being both too 'left' and too 'soft' when interviewing Mr Morrison and other members of his government on its actions and policies. On 6 April, it was the government's response to the COVID-19 vaccination roll-out that she described as 'amateur hour' in a 7.30 Report interview with the Australian Government's chief medical officer Professor Brendan Murphy.

Ms Sales' third book, *Any Ordinary Day*, topped best-seller lists in 2018-19. Conceived after Ms Sales herself experienced a series of devastating events, it captures the stories of people whose lives have been tragically overturned in one day and how each has found ways to live after their personal tragedies. At the dinner, Ms Sales will talk about this book before a Q&A session.

The annual AMA(SA) awards, which like the 2020 dinner were cancelled last year, will also be presented during the evening.

Tickets are available from Trybooking, via the AMA(SA) website.

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Finding the magic in a Taboo

Young Australian of the Year and medical student Isobel Marshall is using her platform to argue for change.

Medical student Isobel Marshall at the Australian of the Year Award presentations in January

As a year 8 schoolgirl, Isobel Marshall became fascinated by a book about the trials of women in Africa who had traumatic birth injuries or fistulas that led to them being ostracised from society.

She was inspired by the work of obstetrician and gynaecologist, Cathryn Hamlin in *The Hospital by the River* to repair these injuries and allow women shunned by the community as 'unclean' to re-gain their self-respect.

The young Isobel reflected that the female reproductive system was at once wonderful and filled with possibility, and equally the source of social injustice, causing many women to be excluded, particularly when they are menstruating.

So when she and school friend Eloise Hall attended a Bond University leadership conference in the summer before their final year of high school, the girls decided to build a business in the menstrual hygiene market and use the profits to help girls and women.

Ms Marshall and Ms Hall discovered that 30 per cent of girls in developing countries leave school when they begin menstruating because it is too difficult to attend lessons, and that many girls in Australia do not have the sanitary products they need.

They also learnt that the lack of menstrual health care and education leads to reproductive complications.

Reckoning that Australians spend $300 million on tampons and other sanitary items a year, the sanitary product market seemed a logical place from which to attack the problem.

This was a catalyst for Ms Marshall to work towards a medical degree at the University of Adelaide and to co-found with Ms Hall the social enterprise Taboo to help overcome 'period poverty' in Australia and overseas.

'Period poverty' refers to both the lack of menstrual hygiene products and the exclusion from school, work and society that occur as a result.

'This natural biological process which prepares a woman's body to have a child – which is amazing in and of itself – this valuable and important process is also the very thing that is disadvantaging many women all around the world and in the most severe cases, leading to their death,' Ms Marshall says.

'This seemed so, so unfair to me. Obviously, Cathryn Hamlin focused on fistulas, which completely changed a woman's life and how she was able to interact, work – all of that – but [reproductive health] is all a taboo, which is why our charity is focused on menstrual health.

'For example, in Australia miscarriage is extremely common but there's not a lot of conversation about healing from that.'

While schoolmates spent their gap year between school and university travelling, Ms Marshall and Ms Hall spent their time sourcing a manufacturer for the Taboo products that would meet their rigorous environmental demands.

They eventually settled on a manufacturer in Spain that uses hydroelectricity as the energy source to produce pads and tampons from organic cotton, and bought 10,000 of two products to sell in Australia.

Through Taboo, and with a team of nine volunteers, they sell environmentally friendly pads and tampons online and through retail outlets to raise money for women without the resources to buy feminine hygiene products. They also conduct programs to empower women, particularly in Sierra Leone and Uganda. Their main goal is to keep a student engaged at school by addressing the barriers that prevent them from attending, including their period.

Profits from sales and sponsorship are more important than ever, with COVID-19 exacerbating the social exclusion of girls, particularly in developing countries where there is limited infrastructure for home schooling. Ms Marshall says it's even a significant issue in Adelaide.

'When you come to issues around menstrual health, in Australia there are huge issues around period poverty,' Ms Marshall says.

'We started receiving a lot of emails from teachers and people in health clinics all around Australia, asking us to provide some of our product to girls who go to school without pads and tampons.'

This is supported by a report released earlier this year by the South Australian Commissioner for Children and Young People, Helen Connolly, which highlighted that about 25 per cent of young people surveyed had trouble accessing sanitary products. Its recommendations included educating young people about the practical aspects of menstruation and providing free access to sanitary products through schools and designated public places.

Taboo's local period poverty program is a pay-it-forward scheme that allows a person to pay $5.90 a month for products on behalf of woman in Australia who needs them. Taboo then puts aside a packet of pads to be distributed to 12 local charity partners, including the APY Women's Council.

Having taken a year from her studies to establish the business and now able to use the platform of the Young Australian of the Year Award to start a national conversation around period poverty, Ms Marshall is ready to take the next steps towards supporting reproductive health.

'It's been great to have the media asking questions about what role do periods play in our day-to-day lives … Having that award really catapulted that discussion and raised awareness and we've had collaborative opportunities that have come from it with people reaching out to discover how we can work together,' she says.

Next year, she will step back from the day-to-day work of running the company and resume her medical studies.

'I am thinking I would like to do something in women's health – if it can be aligned with Taboo, that would be fantastic,' she says. 'I'll always be associated with it even if I am stepping back from some of the practical activities.

'I would love to see Taboo well-respected in the menstrual hygiene market and I'd love to see the conversation around periods and reproductive health care change.'

Ms Marshall says it is time that periods were discussed openly and with a sense of pride.

'In the past this has been a topic of shame that is based on absolutely nothing at all apart from misunderstanding and vilification,' she says. 'Now we understand the importance of this natural cycle and the power it can bring – that it's a sign that a woman's body is healthy and strong – that's something we can celebrate as part of the reproductive process that the human species needs.'

AMA welcomes specialty recognition

After sustained lobbying by the AMA to cut red tape for GPs, the news that the Health Insurance Amendment (General Practitioners and Quality Assurance) Bill 2020 was passed and given Royal Assent was welcome indeed.

From 16 June 2021, GPs will no longer rely on the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM) for confirming their eligibility for Medicare to Services Australia. Medicare eligibility will be automatically linked to a practitioner's registration status and not subject to whether the practitioner continues to be recognised as a Fellow of their college.

Once a GP who has obtained Fellowship is registered in the specialty of general practice, that specialty status will continue to be recognised while the practitioner meets the Medical Board's Registration standard for continuing professional development (CPD) requirements.

Newly-Fellowed GPs will also no longer need to apply to Services Australia to be recognised as a specialist GP to access higher Medicare rebates for their patients. Access to higher rebates will be automatic upon registration in the specialty of general practice, removing another layer of red tape.

There are some transitional arrangements in place ahead of the Bill taking effect - AMA advocacy again helping secure these so GPs who needed to update their registration status with the Board or return to the vocational register could do so. Grandfathering provisions ensuring that GPs who are not Fellows of RACGP or ACRRM, but are on the vocational register at midnight 15 June 2021, will retain their access to higher rebates, if they meet the requirements for general registration.

However, there are, as I understand it, about 3,500 GP Fellows who have not yet registered their specialty status with the Board. These GPs must do so as soon as possible, to ensure their application is processed and specialty status in place. The application fee of $203 is a one-off and tax-deductible fee. Failing to take this step will result in an ineligibility to bill GP MBS items while applying for specialty recognition. For the registration form go to www.medicalboard.gov.au.

Non-Fellowed practitioners who have previously been on the Vocational Register may apply for re-inclusion. While practitioners must have met the CPD requirements of RACGP or ACRRM for the 2017-2019 triennium, recency of practice provisions are being waived to give practitioners the best opportunity to reinstate and retain their access to higher GP rebates.

Once the legislative amendments of the Bill come into effect, GPs, like members of other specialties, will have more flexibility and be able to take control with meeting their CPD obligations. To help GPs self-manage their CPD, the free AMA CPD Tracker is available from doctorportal Learning, which enables tracking multiple CPD requirements at once – very useful for practitioners who have other specialty skills such as anaesthesia or obstetrics.

Dr Richard Kidd, Chair, AMA Council of General Practitioners

AMA Mortgage Broking puts YOU first

A new service with an exciting cashback offer – what's not to like!

There are plenty of new kids on the block but when it comes to your hard-earned money, always stay with the tried, the tested and the trusted. The AMA has now expanded its existing suite of insurance broking and other services by venturing into mortgage broking.

With access to hundreds of loans from a range of Australia's leading lenders, the new mortgage broking service is available to both AMA members and non-members across Australia.

Thanks to its extensive industry experience and lender networks, AMA Mortgage Brokers is best placed to help you navigate through the competitive and ever-changing landscape of loans. No matter the type of loan, be it for your first home, renovating, refinancing or building a portfolio of investment properties – the team will work closely with you to find the right loan to suit your needs.

Sweet Start

To kick off the new service, AMA Mortgage Brokers has unveiled an exclusive Member Cashback offer, which provides all eligible AMA members with up to $2,000* on any loans successfully settled between 4 November 2020 and 31 December 2021.

This exclusive cashback offer is in addition to any bank or lender cashback offer (if eligible) that you receive – giving you more money in your pocket.

If you are not currently an AMA member but decide to join, you will receive the AMA cashback offer plus access to the AMA (WA)'s exclusive Member Benefits Program, where you can enjoy rewards and discounts across a wide range of goods and services from hundreds of retailers across the country.

For more information on the AMA Mortgage Broking Service or its cashback offer, visit amafinance.com.au, email **info@amafinance.com.au** or call Racheal Warne direct on **(08) 9273 3053**.

Hello Racheal!

Helming the AMA's new mortgage broking service is Racheal Warne who has joined the team as a mortgage broker and will work closely with clients to identify a loan to meet their needs. With more than 20 years of banking and finance experience, Racheal will take care of all the legwork, streamlining and simplifying a process that can often be complex and time-consuming. With Racheal leading AMA's mortgage broking service, expect an end-to-end reliable and professional experience.

AMA moves to restore confidence in the COVID-19 vaccine rollout

AMA President Dr Omar Khorshid

Australian state and federal governments need a collaborative effort to restore public confidence in the COVID-19 vaccination program, says AMA president Dr Omar Khorshid.

Public confidence in the vaccine program has taken a battering in recent weeks with debate about the potential risks of thrombosis (clotting) with thrombocytopenia (low blood platelet count) following the AstraZeneca vaccine.

The Australian Technical Advisory Group on Immunisation (ATAGI) moved to recommend that the Pfizer vaccine should be preferred for adults aged under 50 years, causing many to reject the AstraZeneca vaccine. The pace of the vaccine rollout, with just over 1.5 million vaccines delivered at the time of writing, and the GP rollout strategy, have been widely criticised.

Dr Khorshid said the furore had been unwarranted because the vaccines were safe, effective and there was no community transmission of COVID-19 in Australia.

The real problem was confidence, he said, and that's what he and a group of frontline GPs advised the Prime Minister as part of the AMA's plan to reset the vaccination rollout.

'The [vaccination] program is good, the vaccines are good and yet the commentary has been very negative.

'That's really disappointing given the extraordinary position that Australia is in with no COVID and the vaccines going out to over a million people now. We've just got a job to do, and we are just looking forward to getting on with it together.'

The other main constraint was access to the vaccines, which the government was unable to control, Dr Khorshid said. While the federal government had ordered a range of vaccines using different technologies and from different suppliers, including local production, vaccines – particularly of the Pfizer vaccine – remained in short supply.

This situation was expected to improve in the second half of the year with an additional 40,000 doses of the Pfizer vaccine contracted and 50,000 Novavax doses coming online.

'It doesn't matter whether you have big centres, little centres, you can only really deliver the vaccines you've got and our system has been pretty good at getting the vaccine out so far,' DrKhorshid said.

The vaccines were also proving effective with the different strains of the virus.

'The critical thing is that our governments are able to work together, and the state premiers and the PM are able to come up with one plan that is agreed to by all of them and has the buy in of the medical profession and all the health care workers who need to participate in the program so that we can get public confidence back,' Dr Khorshid said.

The AMA has urged state governments to manage mass vaccination centres, focusing on priority groups with the Pfizer vaccine, with GPs delivering the AstraZeneca vaccine to those under 50s in order of priority.

'There is a policy to have mass vaccination centres, but you can only do that with the Pfizer vaccine – focusing initially on health care workers, others in the front line, and then others under the age of 50. That vaccine is very hard to roll out into the community due to the need for very cold storage.

'We need to finish the front line workers first so our message to state premiers is get phase 1B done and get all the vaccines you have into the arms of health care workers - whether they are in your hospitals or GPs, aged care workers, specialists, disability workers - all those people need access to the vaccine as soon as we can. Then the states can move onto the rest of that younger population which is at the lowest risk of COVID, particularly in Australia where we have no community transmission.

'We don't have a huge number of doctors and nurses available to staff clinics and that's why basing the bulk of the roll out in general practice is the right decision. These state vaccination centres are not going to be very big to start with because there isn't much vaccine to give out.

'We've got around 130,000 odd doses of the Pfizer per week at the moment. That is going to increase later in the year but there is no point having a mass clinic and very small amounts of vaccine available.'

Supply would remain a risk because 'there's no magical supply,' and Australia, with only one COVID death in 2021 did not have the right to take it from countries experiencing thousands of deaths, he said.

'The best availability for vulnerable Australians right now is actually in general practice. They have thousands of practices to choose from and that number will increase over time and the availability of appointments will improve,' he said.

'I think we need to trust the experts. They are doing their best to deliver vaccines to Australians and the focus of the program should be that every vaccine that gets into the country gets into the arm of an Australian.'

Lessons learned and still to learn

With a year of experience with COVID-19 behind us, Australian doctors are now considering what we've learned, writes AMA(SA) Councillor Dr Peter Subramaniam

Dr Peter Subramaniam during an online AMA(SA) Council meeting in the early weeks of the pandemic

Some 12 months or so after the COVID-19 global pandemic was declared on 11 March 2020, healthcare systems across the globe remain disrupted. Australian healthcare is no different, despite being largely spared the worst of the pandemic.[1]

Australia has had relatively low numbers of community infections due to the rapid-response public health measures, border controls, secure supplies of personal protective equipment (PPE) and incremental improvements in hotel quarantine programs in our capital cities.

Yet our healthcare systems have been challenged as the so-called secondary pandemic compounded prolonged disruptions that started in March, including delays in non-urgent surgery,[2] delayed presentations of acute stroke[3] and delayed presentation of certain cancers.[4]

The disruption has intensified challenges already facing oversubscribed and under-funded health systems before the pandemic. The singularity of purpose at the initial blush of the crisis in March-April 2020 has given way to the business-as-usual challenges of supply and demand of public hospital beds, and the usual tensions between cost containment and clinical ambition. It has also brought a return to the adversarial positions previously occupied by some clinicians and the health bureaucracy.[5]

South Australia has been – for now – spared the worst ravages of the pandemic. A low infection rate has given us the luxury of time to negotiate the risks and benefits of the vaccination roll-out as issues of risks begin to declare themselves.[6]

While it is possible to say that the South Australian healthcare system has demonstrated an ability to act cohesively and collaboratively to protect our community from the real and potential ravages of COVID-19, it is equally accurate to say that this successful methodology has not naturally translated to managing all the challenges we are now facing.

Our emergency departments are almost predictably unable to provide capacity for demand,[7] there's gridlock caused by barriers to patient flows from acute care, consequential growth in elective surgery waitlists, delays in elective non-surgical admissions, higher numbers of urgent elective procedures crowding into overstretched emergency theatre lists, and unmet demand for mental health beds.[8]

This confirms what we have always known: in the South Australian version of the complex modern healthcare system, demand (predictable and unpredictable) consistently challenges resource and capacity.

The situation is also affected by an exponential skew towards a higher number of more complex presentations to our acute care hospitals,[8] stretched community-based care, and the increasing demands on GPs funded by a separate commonwealth funding model. When viewed through the prism of cost-containment strategies, these post-COVID-19 challenges seem daunting and demoralising for many doctors working within and outside the public health system.

While there are some who cynically suggest that the 're-set' process post-pandemic may be an opportunistic attempt to introduce previously unpopular and resisted reforms (for example, reducing capacity to generate forced efficiencies), we do not have the luxury of relapsing into old ways.

Well before COVID-19 it was noted that our public healthcare system was expensive, inefficient, inequitable, mired in administrative quagmires[10] and, in some circumstances, operating with minimal accountability or clear governance.[11] Change was clearly needed. The pandemic refocussed the system but the case for change remains clear and is largely uncontested.

The change methodology represents a struggle between clinical ambition and cost-containment. This contest cannot (and should not) be avoided but conducted openly to preserve the community trust so evident during COVID. It must involve clinicians (including the technical medical expert and not surrogates), the patient and the administration of an informed government.

These processes can be uncomfortable, but they need not be adversarial. It is necessary to openly (and honestly) contest views to agree on solutions for evidence-based, best patient care.

The issues of cost and sustainability have to be acknowledged, addressed and honestly communicated to the community in a manner that is agnostic of political agendas.

Data is the key language in these contests. Doctors are, by nature, data sceptics – especially when the data does not marry with the clinical narrative experienced in the outpatient or GP clinic, the ward, the operating theatre. When data is used as a driver for change, it must reflect the truth of the clinical narrative and be open to interrogation and explanation.

The relevant medical technical expert must be allowed to engage in this process and data must be appropriately used in modelling projections to inform policy.[12]

Policy translated into directive is only one half of the solution. Successful implementation is the second key half. To this end we need an engaged and effective medical workforce in our public hospital system and our community workforce – specialists, GPs, juniors, trainees and the students who are the future agents of positive change.

There is a sense that the pandemic has passed us by and that we are at the other end of it (vaccination roll-out notwithstanding). This may or may not be a faux sense of security. And regardless of the phase of the pandemic, the current healthcare challenges are real and need addressing.

It remains for us to design a whole-of-system response in the same way that a successful COVID-19 response 12 months ago gave us the trust of the community.

The patients who are waiting in the emergency departments, on the ambulance ramp, on our elective surgery waiting lists, in our general wards and in our communities need us to do this – quickly, effectively and together.

AMA(SA) Councillor Dr Peter Subramaniam is a vascular surgeon and President of the World Societies of Vascular Surgeons.

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Anaesthetists focus on 'proactive wellbeing'

The Australian Society of Anaesthetists (ASA) spent a great deal of time considering the new post 2020/COVID world in the development of our strategic plan for 2021-23. What became very clear over the past year has been the need to acknowledge the importance of mental health and wellbeing for our members. In recognition of this we have included a new strategic priority: 'Proactive wellbeing to foster the personal health and welfare of members, associates and their families'.

This is not a new focus for the ASA. But endorsing wellbeing as a strategic priority sends a strong message of support to anaesthetists. Last year we expanded the range of wellbeing resources provided to members and renewed our commitment to the Long Lives Healthy Workplaces (LLHW) toolkit, which is being relaunched this year.

The LLHW toolkit is designed to help anaesthetists create mentally healthy workplaces so we can reduce risks and stress load in the workplace, improve mental health and general wellbeing, build social connections among peers, and develop action plans to support good mental health and the prevention of suicide.

The COVID-19 pandemic certainly highlighted the risks of acute stress in a crisis. However, it also reminded us of the need for long-term strategies on wellbeing. There are many risk factors that can affect health professionals' mental health and wellbeing at work, with anaesthetists facing some unique factors that can result in mental ill-health, poor general health and an increased risk of suicidal behaviour. The medical profession has a high level of stigma around mental health in the workplace and this is often compounded for anaesthetists because:

- we work in a highly stressful occupation and are exposed to trauma and death
- we have high work demands and may or may not feel a sense of belonging to a particular team in the health services where we work
- we work long hours, experience fatigue and are exposed to on-call stress.

The LLHW toolkit is a locally designed, open access wellbeing framework that was developed with the Wellbeing of Anaesthetists Special Interest Group, funded by the ASA and The Prevention Hub, and progressed by Everymind. More information can be found at www.asa.org.au/llhw

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

Diamonds in a rough time

It's useful to consider what we've learned during the pandemic to help our practices and our patients, writes GP and AMA(SA) Councillor Dr Danny Byrne.

AMA(SA) Councillor and GP Dr Danny Byrne

No doubt COVID-19 forced many unpleasant changes on our lives – even in South Australia where we have been comparatively free of the disease.

Yet personally and professionally (and even at a population level if you follow demographer Bernard Salt), there have been some diamonds among the stones. A momentary slowdown in the frantic pace of life, a reawakening of regional areas and the suburbs, and a new appreciation of personal hygiene are among them.

In general practice, too, there have been some changes for the better because of COVID-19. For example, COVID forced us to jump into the river of electronic communication after hovering on the banks for so many years.

While many had been somewhat sceptical about the need for more electronic communication, My Health Record and health apps such as Medicare Express, COVID-19 forced the pace of take-up with positive effects.

More than ever, doctors and patients alike realised the importance of having electronic access to immunisation records. This is likely to increase if vaccination becomes a de facto entry ticket into many places.

With new Medicare Benefits Schedule item numbers in place for GP consults, we developed new protocols for our professional social distancing designed to maintain our role as trusted advisers to our patients.

The rubber hit the road on e-prescribing, with the number of electronic prescriptions in South Australia increasing five-fold as electronic prescribing was formally expanded in December 2020. About 98 per cent of pharmacies in South Australia have moved to dispense electronic scripts. And, as health administrators noted at the time telehealth was announced as a permanent Medicare subsidised fixture, e-prescriptions will be a great advantage for rural communities, enabling them to have a telehealth consult with a doctor in Adelaide and receive their prescription electronically.

Like many digital innovations, now we have them, we can't imagine what life was like before. We can now print and send radiology films and order pathology tests electronically, streamlining the path from presentation to diagnosis.

We did so much faxing and emailing during the early days of the pandemic and we became accustomed to daily Zoom meeting briefings with meetings documented as practice policy documents. This also prompted us to get better at managing and sharing electronic information. Our PC desktop now has a shared COVID folder with resources, briefings and updates.

At the same time as we were social distancing, in some ways we'd never been closer. The constant changes in COVID messaging meant more regular meetings in our practice. We scheduled early morning meetings with reception staff to ensure we were prepared before the phones were switched over and patient queries were unleashed.

Monday morning was renamed 'funday Monday' after 'ScoMo Sunday' (as the Prime Minister always made announcements Sunday afternoon). And now, 12 months on, we are critically appraising the changes to decide what we will keep and what we will be happy to merely reminisce about in future.

Despite getting a bad rap, Zoom meetings have proved to be pretty handy in our practice – especially given staff comings and goings. It certainly provides a platform to bring us together, and we are getting pretty savvy with the 'best angles', the most interesting backdrops and even remembering to turn off the mute button when we speak. So far, no one in the practice has had the hilarious (if undignified) 'cat filter' left on by their kids, as one unfortunate judge experienced during his working day in the US.

We're keeping the concierge at the front door – not only does it provide a personal touch, but it also helps keep a lid on infection. That's also why we are planning to keep our policy of having patients with respiratory illnesses and the like wait in the car park and come in when we text, rather than have them sit in the waiting room.

We've introduced café buzzers for pathology tests, which allows us to better use our waiting room space, and a scanner for bar code batches of vaccines to expedite the vaccination process. We've also found holding vaccine clinics on the weekend and at retirement villages has helped streamline our vaccination program – especially with the COVID and flu vaccines.

Twelve months on and we're also reflecting about things we'd do differently. For the record, these include:

- always ensuring we have enough PPE and we've revised our minimum stock quantities
- automated billing
- having an offsite office during a shutdown so we could have staff working but not from home. Unlike many other sectors where WFH is now a permanent feature, concerns remain in general practice about privacy and the security of phones and electronic devices, especially if there are other people in the household.

All in all, we'll be pleased when the COVID vax is just another vaccination and the pandemic is a thing of the past, but it does pay to reflect on the diamonds created by the pressure we've experienced.

Outstanding issues

The results of the 2020 AMA(SA) Hospital Health Check (HHC) show little improvement over the year since the 2019 survey was conducted.

AMA(SA) DiT Committee chair Dr Hannah Szewczyk

Outgoing AMA(SA) Doctors in Training Committee chair Dr Hannah Szewczyk says the 2020 Hospital Health Check (HHC) continues to highlight issues that plague junior doctors around Australia, affecting their capacity to provide quality care.

Dr Szewczyk says the pandemic understandably led to issues not directly related to pandemic management being a lower priority for health workforce managers for much of 2020.

'COVID was a big distraction, and everyone was accepting of putting other issues aside during the initial period when hospitals were preparing for significant impacts from the pandemic,' Dr Szewczyk says.

The 2020 Hospital Health Check survey asked junior doctors at South Australia's public hospitals questions including whether they have experienced or witnessed cases of bullying and harassment, unpaid overtime, and anxiety about possible errors due to fatigue. They were also asked to rate the support for their wellbeing in the hospitals in which they worked during the calendar year.

Dr Szewczyk says the survey attracted fewer responses in 2020, with 109 respondents from four hospitals analysed, compared to 239 replies in 2019. However, she says the lower response rate may have been a result of the additional workload and pressure junior doctors have experienced during the pandemic.

'The results demonstrate longstanding issues that are raised whenever health workplace culture and safety are discussed in Australia,' Dr Szewczyk says.

Analysis of the 2020 results examines responses from junior doctors working in four hospitals. It indicates that most junior doctors – between 61.4 per cent at the Women's and Children's Hospital (WCN) and 85.2 per cent at the Royal Adelaide Hospital (RAH) – are concerned about making a clinical error due to fatigue.

These figures were significantly higher than in 2019, when between 43.8 and 69 per cent of respondents were worried about the risk of clinical error.

'These results indicate that many doctors in training are burned out and that patient safety is at risk,' Dr Szewczyk says.

OTHER RESULTS INCLUDED:

Doctor has experienced bullying or harassment:

- Flinders Medical Centre (FMC) 33.3 per cent
- LMH 64.3 per cent
- RAH 55.6 per cent
- WCH 51.2 per cent

Concerned that reporting bullying/harassment may lead to negative workplace consequences:

- FMC - 80 per cent
- LMH - 71.4 per cent
- RAH - 70.4 per cent
- WCH - 72.1 per cent

Dr Szewczyk points to junior doctors' comments as demonstrative of the impact of limited resources and understaffing on their workloads, and consequently on their morale and ability to help their patients.

'An overall theme was that there needs to be funding for more doctors in training to be employed to cover the workload and leave, reduce overtime and improve doctor wellbeing and patient safety,' she says. 'Another common theme was not being paid for meal breaks that weren't taken. She says respondents reported they had been told not to apply for bereavement leave or that bereavement leave was denied because the person who died was not a first-degree relative.

'There needs to be more options for part-time and flexible working arrangements,' Dr Szewczyk says. 'Current rosters are extremely difficult for doctors with young children.'

Dr Szewczyk says she is hopeful that the AMA(SA) Culture and Bullying Summit staged in February 2020 – at which her sharing of the 2019 results prompted shock and distress among many South Australian administrators and practitioners – will have many positive impacts and outcomes.

'I'm hoping now that we have state legislation that Local Health Network boards are responsible for the wellbeing of all staff, they will be motivated to make changes,' she says. 'And if they don't, they can now be held to account.'

2020 Hospital Health Check – respondent comments

'The Women's and Children's Hospital used to be a really enjoyable place to work but due to staff shortages that has changed substantially – everyone is tired and burnt out and overworked.'

'Trainees are feeling unheard and their concerns are not being met.'

'Overall, the people are good, but currently there seems to be an increase in load and not at all enough staff to support this.'

'The RAH has this false reputation for being a centre of excellence. It rides on staff working for free and beyond the scope of their practice in order to function.'

'Improved culture won't come when everyone remains on edge due to staffing shortages and massive workloads. People don't go out of their way to create poor culture, but it is the result of constant systemic under-resourcing. Clinicians are stressed from high workloads, limited breaks, and multiple competing priorities. This doesn't set the environment to cultivate improved culture.'

'At least four weeks' notice of rosters. Currently I often don't find out whether I'm working on weekends etc until the day before.'

Pass it on

Eyre Peninsula GP Dr David Lam and siblings Dr Esther Lam and Dr Nathan Lam are creating podcasts to support junior doctors in both urban and regional areas.

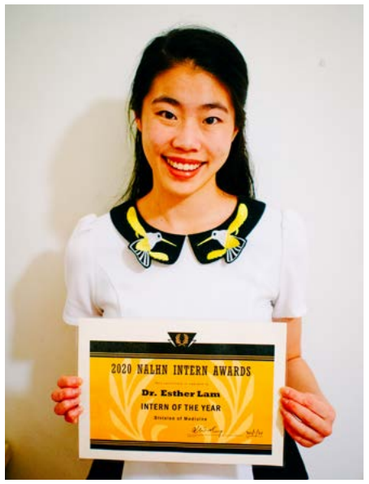
AMA(SA) member and rural general practice advocate Dr David Lam has teamed with 2021 SA Young Achiever Award finalist Dr Nathan Lam and 2020 NALHN Best Medical Intern Award winner Dr Esther Lam to create a medical education podcast based on their careers and experience and to offer tips to support junior medical officers to be the best doctors they can be.

'The *GP Lyf Hacks* podcast is about us using our own experiences as doctors in training to support other junior doctors to get the most out of their training years and be the best they can be,' Dr David Lam says. 'We are trying to promote a positive culture and ensure that being a junior doctor remains a safe space to learn and make mistakes while being supervised by our colleagues.'

GP Lyf Hacks consists of free 20-minute audio tutorials based on real-life cases the doctors have encountered in their careers. Dr Lam says the format was chosen to be the perfect digestible size for the busy rural GP registrar who has limited time, given the demands of their jobs. The audio format also recognises that rural doctors spend a lot of time on planes or driving between major centres.

'The podcast has boomed in popularity during the COVID-19 pandemic in the wake of cancellations of face-to-face teaching workshops due to social restrictions,' he says. '*GP Lyf Hacks* now has hundreds of followers in South Australia and across the country.'

Dr Esther Lam says it has also attracted the attention of medical students and junior medical officers of other specialties who want to develop skills at the level of a rural generalist doctor.



Dr Esther Lam

'We have just released the first episode of Season 2, which specifically caters to the needs of the medical intern,' she says. 'Medical internship is a crucial year, where you are both at your most vulnerable as a new graduate but also where you have all the potential to truly convert book learning into real-life clinical outcomes.

'We try to show that being a doctor isn't just about clinical data. 'Doctors need skills in communication with the patient and with other doctors,' she says. 'Good doctoring relies on knowing how to convey your observations in order to make safe decisions, rather than just the clinical knowledge or procedural skills themselves.'

Top tips for surviving internship

1. LOOK AFTER YOURSELF…

…because if you don't, no one else will. To ensure patient safety, there are endless safety nets that require interns to have most of their work double-checked by senior doctors on the medical team. But there is no safety net to make sure that you are submitting your timesheet to payroll office on time. It is very easy to forget 'life admin' when you are busy with patients, so make sure you make this your utmost responsibility each fortnight and are compensated accordingly for all the good work that you will do.

There is a place for going the extra mile to ensure patient care, and for being a team player to support our colleagues. But you don't need to feel guilty for saying not saying yes to every request to tackle an extra shift or task. Know your own role and responsibilities, to yourself and others, so you can enact your own boundaries without shame.

2. DON'T LET 'ONCE IN A LIFETIME' OPPORTUNITIES PASS YOU BY

'There are things in life that you may never get the opportunity to do again and there are things that can absolutely just wait.' This advice came from intern supervisor and Adelaide-based ENT surgeon Dr Sam Boase, and it couldn't be more true. But you may be tempted to pass such an opportunity if a backlog of administrative tasks awaits. Your main objective as a junior doctor should be to gain real-life clinical experience, not to overcome a mountain of paperwork. Work hard early in the day to complete your assigned tasks, allow yourself the opportunity to scrub in, accompany your seniors to review or admit patients, discuss your clinical conundrums or take advantage of being in the midst of your specialty. It may mean a slight build-up of paperwork in the afternoon but, but that can wait.

Dr Nathan Lam and Dr David Lam

3. ASK LOTS OF QUESTIONS

Internship is great. It is, like medical school, a supervised learning environment, except you are paid by the hour to ask questions! If you don't know something, ask. There is a common misconception among junior doctors that the more questions that you ask of the senior doctors, the more they will think you don't know anything and are incompetent. But most supervisors expect that their interns don't know much, and the more questions you ask, the more you learn - and actually appear conscientious rather than incompetent. Processes vary from specialty to specialty, hospital to hospital, and within a hospital from year to year. Most people will be understanding if you honestly state, for example, 'I've never referred to xyz service before'. Other useful phrases are 'I'm unfamiliar with this', 'I'm new to this role' (followed by a direction-indicating 'so I will follow your lead on this', and 'I'm happy to do xyz, but I'm not very experienced at it and would feel more comfortable if you supervise me'.

If ever as a junior doctor you are asked to do something that doesn't make sense, ask for clarification. Sometimes your boss will say 'this person has diabetes – better talk to endocrine' without actually giving you a clinical question. Don't be afraid to respectfully ask 'Why? What is my specific question for this specialty team?'. It may save you a tedious task that was doomed from the beginning, or better yet you will learn something new.

4. PUT YOURSELF IN THE ON-CALL DOCTOR'S SHOES

The most terrifying task for a junior doctor may be calling the on-call specialty registrar to consult for a patient. It can be extremely humiliating to be 'caught out' with questions to which you don't know the answers and consequently be told off over the phone. However, it is also a great learning opportunity – if you can perfect the 'handover phone call', you must have learnt to formulate and make decisions.

Start by introducing yourself, then check that you are speaking to the right person, and (before revealing too many more details about the case) make clear in the first 30 seconds the objective of the phone call. There is a finite list of objectives, consisting of either calling to facilitate an admission, to consult a patient on the ward, or to seek phone advice. Before calling, make sure that you put yourself in that particular specialty registrar's shoes. Go back and examine the patient yourself before you call. Then ask yourself, 'if I was a doctor of that specialty, what information would be essential to make a decision?' Identifying the crucial information seems like a foreign language when you start, but with practice becomes a matter of pattern recognition. Know what the patient's visual acuity is before calling the ophthalmologist; know what the ECG shows before calling the cardiologist. At the end of your discussion, challenge yourself to propose a diagnosis and management. This can be intimidating, but it trains you be a decision-maker – which is the whole point of the internship exercise. You'd be surprised how often your gut feeling is correct, and you'll be respected rather than viewed as someone who calls with a plethora of random unformulated facts.

5. INTRODUCE YOURSELF TO THE REST OF THE TEAM

Every time you start work on a new unit, make it a point to introduce yourself in person to everyone: doctors, ward nurses, nurse managers and administration staff. You don't have to say anything ground-breaking, simply that you are the new doctor on the ward and that you are looking forward to working together. This does wonders to minimise future conflict and maximise the cohesiveness of the team, and ultimately improves outcomes for the patient.

6. LEARN TO DELEGATE

You are just one person. You can't do everything yourself. But you will be asked to. And so, you need to figure out 'what jobs can only the doctor do, and what jobs can other staff members do? And how can I complete my doctor-specific jobs in a way to enable my other team members?'. We are members of a team for a reason. Useful ways to phrase this is using inclusive language such as 'we' (for example, 'If I complete x, can you complete y and then we can get it all sorted together?')

Dr David Lam is the University of Adelaide's Rural Medicine Coordinator and a former RACGP National GP of the Year. Dr Nathan Lam is 2021 SA Young Achiever Award Finalist. Dr Esther Lam is the 2020 NALHN Best Medical Intern Award winner.

GP Lyf Hacks is available on SoundCloud, Spotify and Apple Podcasts, and is accompanied by online pictorial flashcards on Facebook and Instagram.

More funding for GP visits: AMA

The AMA's 'Care Can't Wait' campaign argues GP visits and more investment in infrastructure will help patients and reduce the costs of aged care.

The AMA is calling for more funding to support and encourage GPs to visit patients in nursing homes, and increased investment in nursing home facilities to make it easier for GPs to deliver the care that people in nursing homes deserve.

The call comes as AMA members report significant barriers to delivering care that deter doctors from visiting aged care facilities.

Problems include:

- incompatible IT systems
- lack of nursing staff to identify patients and assist GPs with clinical handovers
- no clinically equipped private examination rooms are available
- lack of physical access, with no parking and the need for personalised swipe cards and access codes
- lack of adequate financial support for doctors' visits

AMA President Dr Omar Khorshid says these barriers hamper the delivery of quality patient care for our older Australians.

He says most GPs bulk bill their patients in aged care, but they themselves are out of pocket as a result as the current Medicare rebate is woefully inadequate to cover the time spent in nursing homes with patients and on a patient's care outside consultations.

'AMA Members have signaled their intention to reduce nursing home visits and even cease them altogether,' Dr Khorshid says. 'This is the last thing we want right now, when we know our older loved ones are suffering from a lack of medical care inside nursing homes.

'We should be attracting more doctors into aged care by supporting them to take the time away from their busy practices and to visit patients in nursing homes. That way GPs can continue their relationships with their elderly patients who move into aged care.

'We are calling for increased Medicare funding so that GPs can work with nurses to deliver the quality and quantity of care that older Australians expect, and deserve, in a way that is sustainable for the health system.'

The AMA has estimated the additional cost would be $145 million in 2021-22 and $643 million over four years to 2024-25.

'It's a relatively small ask when we've identified over $21 billion of savings that can be made in addressing preventable hospital admissions from aged care," Dr Khorshid says.

The AMA has estimated that over the 12 months to 30 June 2021, there will have been 27,569 admissions of residents from nursing homes to hospitals that were potentially avoidable, costing $312 million and accounting for 159,693 hospital patient days.

The staggering figure is the first national estimate of potentially preventable admissions to hospitals from nursing homes alone. In total, new AMA modelling has identified $21.2 billion of savings that could be made over four years if immediate reforms were implemented to Australia's aged care system.

The $21.2 billion comprises four-year savings from potentially avoidable admissions to private and public hospitals from nursing homes ($1.4 billion), from older people in the community ($18.2 billion), those transferred to emergency departments but not admitted ($497 million), re-presentations to emergency departments within 30 days ($138 million) and people waiting in hospital for a place in a nursing home ($887 million).

Details of the modelling are contained in a new report from the AMA, Putting Health Care Back Into Aged Care released last week as the centrepiece of the AMA's continuing 'Care Can't Wait' campaign.

'The potentially preventable hospital admissions - just one aspect of the current nursing home experience - show there are substantial savings to be made with immediate reform,' Dr Khorshid says.

'We believe these hospital admissions, presentations and stays could be prevented through better provision of primary care in aged care settings and that means investing in GPs and registered nurses.'

AMA(SA) President and GP, Dr Chris Moy, who has many patients in aged care, says there are a whole raft of non-contact activities carried out by GPs to support their patients.

'Things like needing to discuss treatment with relatives and nursing home staff – it's almost like looking after three patients, not just one - as well as the mountain of paperwork that goes with that takes time and doctors must be supported in doing this,' Dr Moy says.

'Technologies including My Health Record, My Aged Care, nursing home IT and GP clinical software all need to be able to talk to each other for the benefit of the patient and all involved in their care. And nursing homes need clinically equipped examination rooms to preserve the person's dignity.

'Just making sure a GP is supported in visiting a resident who has deteriorated can make the difference between them having to be transferred to hospital or not. Being able to treat the resident in their home is better for the individual and the health system.'

'All of this speaks to our call to put health care back into aged care by boosting the number of doctors and nurses in aged care.'

Opportunities unfold

General practitioners (GPs) should be supported to provide early medical abortions, both clinically and with a new Medicare item number, says new AMA(SA) Councillor Dr Brian Peat.

AMA(SA) Councillor Dr Brian Peat

Women's and Children's Hospital senior consultant obstetrician Dr Brian Peat says South Australia's new *Termination of Pregnancy Act*, which treats abortion as a women's health issue rather than under criminal law, provides an opportunity for general practitioners (GPs) to provide early medical abortion and increase access for women who need it.

'There's a huge gap for patients because the law relating to terminations of pregnancy,' he says. 'The law before 3 March demanded that all abortions be performed in a gazetted hospital such as the Pregnancy Advisory Centre. This legislation is transformative for South Australia because it means that GPs and (sexual health service provider) SHINE and places like that can provide early medical abortion.'

Dr Peat says the change is even more significant in regional areas. 'There are some GPs who are performing early term abortions in regional areas at their local hospitals for example, in Naracoorte, Clare and Pt Lincoln but there probably could be improved access for patients at Whyalla or Port Augusta for example. The new legislation creates opportunities for doctors to provide the medication required for early term abortions through their clinics.'

'A lot of people still travel to Adelaide to have basically two tablets – now, they'll be able to see their GP and take them at home.'

However, he says, while it is important that more GPs provide this service, many doctors are likely to be fearful.

'We would like some strategic people to provide this service but from experience I think many doctors who could – or even want to do it – will think it is too hard,' he predicts. 'They are likely to say: What if I miss an ectopic? What if I make a mistake?

'I want to convince them that it is not that difficult. It's actually quite easy and a practical thing to do.'

Dr Peat will work with the GP representative on the AMA(SA) council, Dr Bridget Sawyer, to provide that support. 'There are also some issues around remuneration – it's a case of lobbying the Federal Government for a new Medicare item number,' he says.

Another key issue for the specialty is the size and cost of the new Women's and Children's Hospital, which he says suggests the need for 'creative thinking' in how to manage budget constraints.

'… the baby business and birth numbers appear to be booming with the WCH putting on additional clinics to cope with demand …'

'There appears to be a budgetary cap from Treasury and there's also a problem with the site footprint,' Dr Peat says. 'There's a lot of discussion around the possibility of making the new hospital 20 per cent smaller than the existing hospital.

'There are ambitious plans for how we want to expand paediatrics, to expand maternal foetal medicine, and expand the services we provide – yet here's the government saying we can't afford that and we want to offer a hospital that is 20 per cent smaller, which is what happened with the RAH.'

He suggests the solution could be to lobby for satellite centres in northern Adelaide.

'We need to come up with better solutions rather than saying we want 50 per cent bigger and you want 20 per cent smaller – we might have to come up with some more imaginative solutions,' he says.

'Let's set up a real satellite, properly funded, properly staffed, let's do that from the outset.'

Dr Peat says that a year after the pandemic began, the baby business and birth numbers appear to be booming with the WCH putting on additional clinics to cope with demand.

'Some of my colleagues say there are not enough trainees in this specialty and there are not enough people who want to go to the country to work despite the ongoing need and that is an issue the AMA will need to continue working on,' he says.

Even practitioners in the Adelaide Hills struggled to attract sufficient specialists to meet demand, he adds. 'This is where the AMA(SA) can continue to work actively, to help redress this problem.'

The other COVID issue looming for the profession is whether pregnant women felt safe to have COVID-19 vaccines. While the advice is as yet unclear, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists suggest there is not enough evidence of safety to recommend routine use of COVID vaccines.

With us for life

Long-serving members of the AMA were acknowledged at a COVID-safe gathering in April.

The service and achievements of South Australia's newest AMA Life Members were celebrated at the showrooms of association partner Mercedes-Benz Adelaide on 17 March.

AMA(SA) President Dr Chris Moy told the group of members and partners that the AMA of today is built on the work and commitment of doctors who have devoted their lives to the medical profession.

'As we continue to advocate for members and patients through the pandemic, we thank you for your contributions,' he said.

Dr Moy and CEO Dr Sam Mead met those members who were able to attend an event altered in timing and format due to pandemic restrictions.

The group was led by Dr Roy Scragg OBE AM, whose 75 years as an AMA member and recent 97th birthday earned a special invitation to the gathering. It has been an exciting year for Dr Scragg, who was recognised as a Member of the Order of Australia (AM) in January.

New Life Members A/Prof Robert Penhall, Dr David Williams, Dr John Whitford, Dr Neville Minnis, and Dr John Hill joined Dr Scragg at the morning tea. Dr Moy also congratulated their colleagues Professor John Crompton AM, Dr Carmine De Pasquale and Dr Firoze Narielvala, who were unable to attend.

DR ROY SCRAGG AM OBE

Dr Scragg is a pioneer among epidemiologists in Australasia.

He went on to produce what the World Health Organization described as the most complete epidemiological study on the prevalence of infertility, pregnancy wastage, and child loss.

Dr Scragg famously discovered that the declining population in several towns was due to a gonorrhea infection.

'If I had taken the position in Arnhem Land, I may well have postulated the same cause but I would not have had access to an x-ray machine and would not have produced what WHO described in 1975 as "the most complete epidemiological study on the prevalence of infertility, pregnancy wastage, and child loss",' he says.

He went on to become a professor and Director Public Health in PNG, expanding medical care, research, prevention and education; and facilitating seminal studies related to Jakob-Creutzfeldt disease (kuru), neonatal cretinism, enteritis necroticans, neonatal tetanus and pneumococcal disease.

In 1960, an American colleague at Atlanta CDC dubbed Dr Scragg as 'an epidemiologist'– the first time he'd heard the term. 'Disease had an epidemiology but there were no positions designated as epidemiologist,' he says. 'I had considered myself to be a medical demographer.'

Dr Scragg maintained his clinical skills by filling GP locum positions until he was 80. He is now working on a book about the 3,000-year history of gonorrhea which he jokes he is calling 'Germs and Sperms'.

'There are many disciplines and opportunities for people to make a contribution to medicine,' he says. 'It's just a matter of choosing one – and if you work at it, you will be successful.'

PROFESSOR JOHN CROMPTON AM

As an eminent (1984-2017) and a member of the Army Reserves from 1965-2011, Professor John Crompton might have been busy enough.

Trained in London, Melbourne and Adelaide, and specialising in neuro-ophthalmology, medico-legal issues and eye trauma, Professor Crompton has been in the vanguard of teaching and practice in complex ophthalmology.

But it was the joy of helping people in the Solomon Islands in the early 1980s that Professor Crompton says inspired him.

Pictured at the Life Members' morning tea in March are (from left): A/Professor Robert Penhall, Dr David Williams, Dr John Whitford, Dr Chris Moy, Dr Samantha Mead, Dr Neville Minnis, Dr Roy Scragg OBE AM, and Dr John Hill

'When I worked in the Pacific in the 1980s and 90s we went to many of the atolls (island nations) where they don't have enough GPs or population to support specialists,' Professor Crompton says. 'There we provided a service, restoring sight and I really found it very rewarding.'

A former head of the neuro-ophthalmology service at the Royal Adelaide Hospital, Professor Crompton has been involved in more than 40 teaching tours to the South Pacific, SE Asia and China, as well as ADF surgical trips to remote Australia. He provides training for local doctors in neuro-ophthalmology and supports an in-bound fellowship program.

The training program has moved online to provide ongoing support to doctors throughout Asia with Sight For All, and plans to resume its in-bound fellowship program to countries such as Cambodia as soon as possible. His work earned him a Member of the Order of Australia award in January 2021.

'If we bring people to do fellowships here, that country loses them for a year and we are teaching them on our patients, with our investigations and our treatments,' he points out. 'We've learned that it's far better to do in-country fellowships where possible and we use their patients, their language, their investigations and their treatments.'

DR CARMINE DE PASQUALE

The road that led to Carmine De Pasquale's graduation from medical school was bumpier than most, beginning in Naples in 1958, including a stop at Modena, and then acceptance at the Adelaide Medical School in 1964.

He migrated to Adelaide in August 1962. With knowledge of Italian and French but limited English, he finished his medical course in 1969, interned in 1970, and began psychiatric training in 1971. He went on to work as a consultant at Enfield and Hillcrest hospitals and as Director of Psychiatry at the Beaufort Community Clinic in Woodville.

'Beaufort became a multicultural community clinic with a large clientele of Italians – the only clinic in South Australia with bilingual staff including a bilingual psychiatrist,' Dr De Pasquale recalls. 'It was at Beaufort Clinic that I introduced the concept of "Hospital at Home" for Italians with severe psychiatric disorders.'

In 2015 he received the Royal Australian and New Zealand College of Psychiatrists' Meritorious Service award for the introduction of the Hospital at Home services.

Dr De Pasquale continues to work one day a week, seeing about 60 chronic patients whose care he has managed for many years. He is a board member and former president of the Italian Benevolent Foundation, Aged Care, pleased he could help develop an organisation that now has assets worth more than $100 million

DR JOHN HILL

It was a distaste for the 'bitterly cold' weather in Corby in Northamptonshire, England, that led Dr John Hill and wife Ann to consider migrating to somewhere warmer. Library research and a job offer for Dr Hill led them to Tea Tree Gully, where Dr Hill remained in private practice until his retirement.

Dr Hill graduated from the Bristol University in 1960. He arrived in South Australia eight years later.

We wanted something warmer so ruled out Canada, and when a job was advertised in the British Medical Journal, made our way to Australia', he says.

'I was taken on on a three-month trial and I've been in Tea Tree Gully ever since.'

Dr Hill says he enjoyed watching the practice grow, and the sharing of information and ideas that came with the GPs' access to visiting specialists.

'Medical practice has changed so much,' he says. 'It's much more intelligent and cohesive. And I've always appreciated the support you can call on, such as pathology services.

After retiring, Dr Hill spent 14 years as a medical crew member for the Simpson Desert Cycle Race. He and Mrs Hill also travelled overseas extensively until her death about five years ago. He continues an active interest in silverwork and the local Gem and Mineral Club, which was sparked by Mrs Hill's earlier career in gemmology, and spending time with his family.

DR NEVILLE MINNIS

Dr Neville Minnis graduated from the University of Adelaide in 1963, after choosing to study medicine as the launching pad of a career 'that would be worthwhile and challenging'.

He chose ENT and head and neck surgery as 'a specialty with a whole spectrum of procedures for a complicated part of the anatomy, and we had a wide diversity of patients, from the elderly to little children'.

'There are so many interesting procedures – from microscopic ear surgery to radical head and neck cancer surgery,' he says. 'It's all become sub-specialised now, but in my day, we were fortunate enough to do the lot.'

Dr Minnis trained in London and Bristol.

He returned to Adelaide and embarked on a career including more than 20 years at the Queen Elizabeth Hospital, and private practice at inner-suburban Hyde Park and on North Terrace. He nominates the development of a vaccine against the human papillomavirus (HPV) and the advances of radiology in CAT scanners and magnetic resonance imagery as two of the 'transformative' developments during his years in medicine.

Dr Minnis retired in 2009. He is now 'hands on' as a painter and sculptor, travels when he can, and spends much of his time on Hindmarsh Island with family.

DR FIROZE NARIELVALA

Retired physician and gastroenterologist Dr Firoze Narielvala has seen 'enormous change in many spheres' since graduating from Calcutta University in 1953.

'Medicine then was vastly different,' he says. 'Infectious diseases were rife, including smallpox, cholera, tuberculosis, dysenteries, poliomyelitis. tetanus, typhoid, filariasis, malaria.

'Immunology was basic and rudimentary. Antibiotics were non-existent. Radiology and imaging were utterly basic and minimal.

'There has been so much change in medicine, communication, electronics and technology. Those were analogue days.'

Dr Narielvala lectured at Madras, Benares Hindu and Bombay universities, and was a Commonwealth Fellow invitee to the 1969 Asian Oceanic Congress of Gastroenterology.

He migrated to Adelaide in 1970, and was consultant physician and director of gastroenterology at the Repatriation General Hospital (RGH) from 1972 to 1998, during which time he represented the AMA at conventions and on ministerial delegations to India.

Dr Narielvala retired in 2003.

'My sentiments as I look back on my career can best be summed up in words of Sir William Osler: 'The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head",' he says.

ASSOCIATE PROFESSOR ROBERT PENHALL

The realisation that biochemistry could be applied to human beings prompted Associate Professor Robert Penhall to choose medicine a career. Later, it was the fact that his passion for biochemistry had led him to train in clinical pharmacology

and general medicine that resulted in his being offered a position as a geriatrician at the RAH, in what was then the new field of geriatric medicine.

'It was the concept of being a thinking doctor that led to me becoming a physician,' he says.

Associate Professor Robert Penhall says the 'most amazing' part of his career was that Adelaide at one time had domiciliary care services, integrated with rehabilitation and acute care services, that provided continuity of care so unusual that local services attracted visitors from around the world.

He ran the RAH's Department of Geriatric and Rehabilitation Medicine for 30 years, at the same time working with Hampstead Hospital, the Eastern Domiciliary Care Service and the University of Adelaide as 'doctor, clinicians, administrator, teacher and researcher'.

Associate Professor Penhall retired in 2012.

DR JOHN WHITFORD

Dr John Whitford was attracted to ophthalmology because of its combination of medicine and surgery and the technology associated with its practice.

'As an undergraduate I enjoyed the teaching, and then as a casualty resident, I seemed to see a lot of ophthalmic pathology and gained confidence,' he says.

Following his graduation as an ophthalmologist, Dr Whitford undertook a retinal fellowship at the Sydney Eye Hospital in 1979, and then returned to join a private practice on North Terrace. Once a fortnight, the Port Lincoln-born young man would return to consult in his hometown.

His practice later established rooms in Kingswood, where he spent his latter years.

As an extension of his retinal interests, he examined extremely premature infants at the Women's and Children's Hospital and was responsible for introducing laser treatment for the more advanced cases.

Five years after his retirement, Dr Whitford nominates as significant changes during his 36 years as an ophthalmologist the advances in cataract surgery with intraocular lens implantation, and intraocular injections for 'wet' age-related macular degeneration.

Now he spends much of his time on the golf course, has embraced painting, and enjoys gardening and spending time with his grandchildren.

DR DAVID WILLIAMS

It was the appeal of being able to combine surgery and physician work that led to Dr David Williams selecting ENT as his specialty.

He'd graduated in 1970 – the same year as fellow new Life Members Drs Crompton, Penhall and Whitford – and felt he 'would be able to function better in surgery'.

'ENT gave me physician work and surgery in the same specialty, and enabled me to work right through all age groups.'

He particularly enjoyed working with children and over the years found more than 60 per cent of his work was in paediatrics.

He nominates as highlights in ENT the development of laser surgery, endoscopic surgery and cochlear implants.

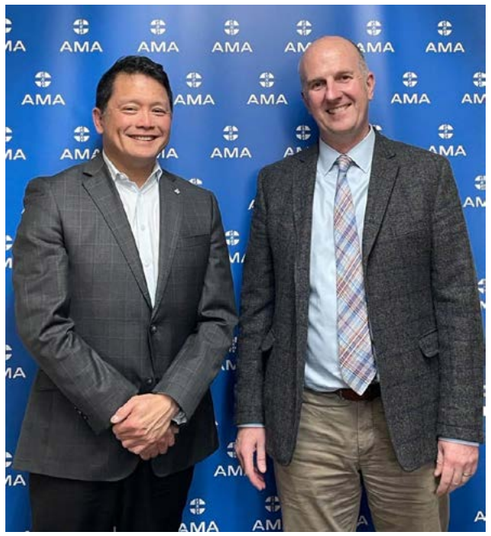
'I really enjoyed my medical work, and working to help patients,' Dr Williams says. Dr Williams now directs much of his energy at helping the environment. He plants trees near Quorn 'to appease my negative climate activities'.

A job well done

As the presidency of Dr Chris Moy entered its final weeks, Health and Wellbeing Minister Stephen Wade asked that the regular meeting with Dr Moy and Vice President Dr Michelle Atchison be held at AMA(SA) rather than in his office in Hindmarsh Square.

During the 20 April meeting, Minister Wade thanked Dr Moy and AMA(SA) for the ongoing advocacy and efforts to secure better health outcomes for South Australians, and for helping relay calming messages of reason, during the pandemic.

The meeting also included Dr Michael Cusack, who has recently been named Chief Medical Officer in South Australia after acting in the role.



Pictured above, AMA(SA) President Dr Chris Moy with South Australia's Chief Medical Officer Dr Michael Cusack; and left, with Health and Wellbeing Minister Stephen Wade and AMA(SA) Vice President Dr Michelle Atchison.

Feet first for doctors' mental health

Dr Chris Moy pictured during the 2020 #Crazysocks4docs campaign

Campaign founder and Victorian cardiologist Dr Geoff Toogood will launch the 2021 #Crazysocks4docs campaign through a special video message to South Australian supporters at the annual breakfast on 4 June.

Dr Geoff Toogood founded the #Crazysocks4docs campaign as a means of reducing stigma surrounding the mental health of doctors.

He will appear via videolink at an event to be hosted by Doctors' Health SA Medical Director Dr Roger Sexton.

Dr Sexton encourages doctors to participate in an enjoyable social event with a focus on the importance of their own and their colleagues' mental health and wellbeing.

'We invite all South Australian doctors, medical students and their partners to grab their most colourful socks and join us to highlight the importance of reducing the stigma around doctors' mental health, and of the need for clear and trusted pathways of care for any doctor who requires medical support and professional assistance," Dr Sexton says.

Special guest Professor Michael Kidd, Deputy Chief Medical Officer in the Australian Department of Health, will share his personal and professional strategies for managing a very challenging time in his high-profile role. An expert panel will discuss current initiatives and supports in place for doctors and medical students and some of the current issues that need more focus.

MC is Paul Kitching of communications agency Fuller, who through his 'Coffee with PK' online coffee meetings turned the 'negative' of COVID into a networking and friend-making experience for businesspeople in Adelaide and beyond.

The 2021 breakfast is organised in partnership with Doctors' Health SA, SASMOA and ASMOF (SA Branch). It will raise funds for Dr Toogood's CrazySocks4Docs Foundation, which invests in vital initiatives that support doctors' mental health.

The breakfast will be staged at the Adelaide Convention Centre on Friday 4 June, starting at 7 am. The 2019 CrazySock4Docs Breakfast sold out early, so book your tickets now via link.

New campaign encourages quitters

SA Health, in partnership with the Australian Medical Association (SA), is encouraging South Australian smokers to have a go at quitting smoking this May in a national first – the 'Quit your way in May' campaign.

'Quit your way in May' invites smokers to set themselves the goal of quitting smoking for an entire month or a period of their choice. They are encouraged to quit smoking their own way, by trying out a variety of quit smoking methods to see what works best for them.

Doctors are encouraged to talk to smokers about 'Quit your way in May' and direct them to the tools available. As it usually takes multiple attempts to successfully quit smoking, it's important to encourage smokers to have another go and 'Quit your way in May' provides this opportunity.

Smokers can register to receive regular emails of support with tips and information throughout their quit attempt, including the advice to visit their GP before they quit smoking.

These include a cost calculator where smokers can find out how much money they could save if they quit smoking and a timeline of the body's recovery after quitting smoking.

As having a plan for quitting can increase the chance of success, the website also has a tool for making a quitting plan, which can be completed in a couple of minutes.

The best way to quit varies from person to person, so a one-minute quiz is also available to help smokers find out why they smoke and to direct them to strategies that best suit them.

Smokers are often interested in hearing about real quitting experiences, so stories from people who have successfully quit smoking are also available on the website.

There is also a distractions tool with videos, activities, challenges and podcasts to help smokers get through nicotine cravings without picking up a cigarette.

A Facebook support group has been created where smokers can discuss their quitting experience with others.

'Quit your way in May' is also supported by the Heart Foundation and Quitline (13 7848). To find out more, visit www.quityourwayinmay.com.au.

Dr Rajaram Ramadoss
Ordinary Member
AMA(SA) Council

AMA(SA) Council Meeting March 2021

The continued work of AMA(SA) President Dr Chris Moy in standing up for doctors and patients throughout the many months of the pandemic was applauded by the AMA(SA) Councillors present for the meeting on 4 March 2021.

Councillors expressed overwhelming appreciation for Dr Moy's efforts, which had started in January 2020 and did not slow down – in fact became more intense and urgent – as the pandemic progressed.

At the March meeting, the ongoing debate over COVID-19 vaccinations' efficacy and complications was discussed, along with the potential ramifications for doctor and patient confidence and willingness to be vaccinated.

Council highlighted the 'complex' issue of whether vaccination should be compulsory, including for workforce sectors such as medi-hotel security staff, residential facility staff, and healthcare workers.

Discussion turned to the seasonal flu vaccine, and implications for patients as the rollout of the flu vaccine increasingly overlaps with the delivery of the COVID-19 vaccine.

Councillor Dr Claire Pridmore reported on a recent 'encouraging' meeting about the plans for the new Women's and Children's Hospital with Health Minister Stephen Wade. Dr Pridmore said she had conveyed to the Minister the concerns of AMA(SA) Council and clinical colleagues about the capacity of the planned hospital, and our view that data demonstrating current need and predicting future usage should be the basis of calculations for the capacity of and facilities in the hospital.

Dr Moy updated the Council on the Termination of Pregnancy Bill, which had passed the Lower House the previous week, thanking Councillors for input and support during the months leading to the votes in the Upper and Lower Houses. He also warned that similar 'tactics' may be used to sway parliamentarians as they prepare to consider legislation relating to voluntary assisted dying in the coming months.

Life edits and optimisation

'Any advanced technology is indistinguishable from magic.' – Arthur C Clarke

Dr Troye Wallett is a GP who is currently optimising for opportunity but reserves the right to change his mind. Mind-worms infest his thoughts; keeping them in order requires putting ideas on paper or discussing them. If you have any mind-worms to discuss, email him at troye@troyewallett.com

'On Wednesday, I am doing a life edit,' a colleague said, sparking a cascade of thoughts, questions and inspirations.

The conversation that followed was deep and meaningful in the best way, starting with consideration and clarification of many aspects of life and what's important. And then the thought process persisted over several days, creating fertile conditions for insights. The 'edit your life' mind-worm leads us along many tunnels.

A CONSIDERED LIFE

The editing process starts with carving time for the task and putting distractions aside. The next step involves contemplating one's values, purpose and goals. It can be confronting, but it is valuable. If you're not sure about identifying your values, a quick Internet search can find a million articles and questionnaires designed to help you establish them.

It's a good start but gets overwhelming quickly. The proposition therefore is to ask this practical and actionable question: 'What am I optimising for?'

'Optimise' in this setting is relates to setting up the conditions for things to thrive. For example, if being a concert pianist is my goal, I need to play the piano regularly. To do this, I need a piano, and I must allocate time to playing. Arranging lessons and committing to playing in public sets up more conditions for success. Success can never be guaranteed, but failure is certain if I don't pay attention to the conditions for success.

Ask the question in the present as a baseline. 'What am I currently optimising for?' For clues, look at your calendar and credit card statements and see where your time and money are spent.

Ask the question in a way that looks at your future, to guide the edits: 'What do I want to optimise for?'

Consider how the two answers differ. Ask the question at different times because things change. Ask the question without judgement, because judgement is seldom helpful.

TRY NOT TO JUDGE

Judgement is a narrative with limited use. Judging people and their actions often reveals a lack of empathy. Judging emotions and thoughts leads to self-criticism. People are generally trying their best, and feelings are for feeling. Accepting people for who and what they are generally has better outcomes.

Judging the answer to the 'optimising' question is also unhelpful. For example, sometimes 'wealth creation' is important, to secure our health and that of family members.

It is not about judging but rather about making considered choices.

OPTIMISING FOR WEALTH

Being motivated by money has a bad rap. However, there are times when wealth creation is a necessary focus. As with everything, there are choices to make. Do I maintain or increase my standard of living or prioritise life choices that require less money?

The key is to recognise and embrace why we have chosen wealth creation over other values or objectives, and recognise and understand what sacrifices we are making when doing so. This is true for every choice.

If I follow this mind-worm down the wealth creation path and explore all the advice regarding wealth creation, I could write a book. Others have done this, however, so here are some recommendations:

- *I Will Teach You to be Rich* by Ramit Sethi is a good guide; some chapters based on US regulation can be ignored.
- *Barefoot Investor* by Scott Pape, which suggests that learning how to live within your means is critical to wealth.

OPTIMISING FOR HAPPINESS

This choice is an obvious one but is possibly the hardest to implement. The challenge is to identify what happiness means for you. Sitting on a beach, drinking cocktails, and reading is all well and good, but is unlikely to lead to long-term happiness.

Derek Sivers talks about being 'shallow happy' versus 'deep happy'. 'Shallow happy' comes from being present-focused and hedonistic. It is enjoying pizza and beer or binge-watching a Netflix show. 'Deep happy' is future-focused and follows difficult and hard work. It is running a marathon or volunteering. It generally comes as a result of hard, challenging effort. 'Deep happy' is a job well done.

It is tempting to say that 'shallow happy' is inferior to 'deep happy'; however, they are both necessary in a balanced life.

There are myriad books written on seeking happiness. A good one is *The Happiness Advantage* by Shawn Achor.

OPTIMISING FOR OPTIONS

The world is abundant, which is both a blessing and a curse as there are so many options to consider and paths to follow. Choosing one path means there are others that cannot be selected. For example, doctors walk the healthcare path, which means they close the engineering path. (Switching paths is not impossible, just difficult).

The 'What am I optimising for?' question is a decision-making tool that helps decide which path to walk. If the aim is to optimise for options or freedom, then the path with the most branches is chosen. Disposable income gives more options as does having fewer demands on our time. Knowledge reveals more opportunities.

The dark side of having too many options is the anxiety that choice can bring. An undefined life is scary. An advantage of studying medicine is that our careers are mostly mapped from day one. Finishing university with an arts degree may make the world your oyster, but deciding on life's direction and commencing study for one profession can be overwhelming. Optimising for options or freedom can be a good strategy for success but requires some consideration.

No book recommendations directly relate to this one, but the excellent *The Art of Possibility* by Rosamund Stone Zander touches on the idea.

OPTIMISING FOR X

Choices abound when it comes to optimising – optimising for fitness and sport, for health, for luck, or for 'X' (where X is the thing being optimised for) are some ideas that emerge when the mind-worm is set free. Every life is optimising for something, whether considered or not. If you increase the surface area for something to occur, the chances are it will happen. That is what optimising is about.

ASKING THE WRONG QUESTION?

Fortunately, what we optimise for is not a black and white choice but rather a pie chart. How much of your life is optimised for happiness? Wealth? Opportunity? Maybe the correct answer is to optimise for a beautiful, balanced life. In that vein, perhaps, it is not about making massive life-edits but rather small adjustments and trending towards a beautiful life. Perhaps, *optimising* is the wrong word choice because it is cold and clinical. Perhaps, life is less like editing a book and more like continuously painting an artwork. Optimising for a beautiful life-painting may undermine this article's entire premise but releases the next mind-worm, which is delightful.

'... The dark side of having too many options is the anxiety that choice can bring ...'

Parental leave and gender equality

SAM PAULL
STUDENT NEWS:
FLINDERS UNIVERSITY

A look at the recent news coming out of the nation's capital has again highlighted the many and varied ways that gender inequalities exist within Australian workplaces, and in this medicine is no exception. There is still a long way to go before genuine gender equity is achieved in the Australian medical workforce, with a significant gap in both wages[1,2] and leadership positions.[2,3] One potential way to tackle this issue is through a 'small wins change model' approach,[4] where small measurable 'wins' motivate further action and organisational change. With this approach in mind, I would like to discuss the idea of implementing a shift in workplace culture through addressing parental leave equity.

Existing paternity leave arrangements across the majority of medical officer and specialty program roles leave much to be desired, with as little as one unpaid week of paternity leave being available in some cases. The 2020 AMA(NSW) Hospital Health Check demonstrates a general dissatisfaction with paternity leave access, with 40 per cent of respondents feeling their access was very poor or poor.[5] Increasing access to both parents taking concurrent leave would provide fathers more time with their children and more time to support their partners; evidence suggests it may also increase earnings equality. In 2006, Quebec introduced a parental leave scheme with five non-transferable weeks for fathers and found it led to mothers earning on average an extra $5,000 a year.[6] More flexible and equitable parental leave arrangements may also influence the choice of career direction for medical students and junior doctors, with considerations for family planning often weighing heavily into decisions of which pathways to follow.

The concept of parental leave reform is not a novel one. In a recent position statement on support for parents in medical training, the AMA called on the government to increase access to equal and reasonable parental leave entitlements for both parents. This position is shared by groups such as the Business Council of Australia, and large consultancy firms such as KPMG. Ultimately, changes to parental leave are just some of the many reforms that are required to achieve gender equality in the workplace. But they do have a role in effecting a cultural shift, a 'small win' if you will, that for aspiring doctors might have a big impact.

1. *Schurer, S., Kuehnle, D., Scott, A. and Cheng, T.C. (2016), A Man's Blessing or a Woman's Curse? The Family Earnings Gap of Doctors. Ind Relat, 55: 385-414.*

2. *https://www.amansw.com.au/are-we-there-yet/*

3. *Burgess S. et al. Gender equity within medical specialties of Australia and New Zealand: cardiology's outlier status. Intern Med J. 2020 Apr;50(4):412-419. doi: 10.1111/imj.14406*

4. *S. J. Correll,Reducing Gender Biases In Modern Workplaces: A Small Wins Approach to Organizational Change, Gender & Society, December 2017, Vol. 31, Issue 6, Pages: 725-750.*

5. *https://ama.com.au/media/support-needed-parents-medical-training*

6. *https://theconversation.com/reforming-dad-leave-is-a-baby-step-towards-greater-gender-equality-144113*

Turning a corner

PATRICK KENNEWELL
STUDENT NEWS:
ADELAIDE UNIVERSITY

The return of pre-clinical students to campus this year has brought two cohorts of fresh faces into the Adelaide Medical School and has been met with a feeling of a return to some normality. It has been exciting both for the new first years and the second years who spent their first year online to get to know their peers.

With a year of digital learning under their belt, students have found a huge appreciation about the value of face-to-face education and events. Teaching this year has evolved into a hybrid model: tutorials and clinical-practice sessions for pre-clinical students are delivered face-to-face in a social-distanced format while lectures remain online for the foreseeable future.

The AMSS has managed to run all of our usual events but in modified formats this year ensuring that we maximise the opportunities for our members, while working closely with the university and SA Health to ensure we remain COVID-safe. We ran a series of workshops in collaboration with a large number of student clubs for the first years in O-week,. including suturing, a birthing workshop, meditation and mindfulness and a Q+A session. We capped this off with a modified Skullduggery-themed Backyard Shenanigans run on the Barr Smith Lawns with the assistance of the university, Adelaide University Union and Unibar.

It was a very different atmosphere to Skullduggery of old with lawn games, food trucks, sit down drinks and, unfortunately, no opportunity for a dance floor due to restrictions. Despite this it was very inclusive, well attended and well received by all who went.

We were fortunate to be able to run Medcamp, with first years making the most of the opportunities to get to know each other, learning some important clinical skills, and demonstrating sporting prowess at a Sports Day at Carrickalinga beach and in our annual rugby games against the older years.

Our first educational event for the year was a forum on Refugee Health, which had a great turnout for speakers Dr Grace Goodwin and Ms Elly Sarre. We are also getting our educational mentoring programs Peer 2 Peer and Med Transit started for the year to increase opportunities for our first and second year students to meet students in other years.

An exciting addition to the AMSS this year is our podcast 'Catch Up with the AMSS', which you can find on all podcast platforms. We are using this to update our members on what is happening around campus and to create some great educational pieces, including one with previous AMSS President Dr Simon Cousins. If any alumni are interested in participating in the podcast, please email vpc@amss.org.au.

Key advocacy priorities for the AMSS this year include access to COVID vaccinations for medical students. We are very grateful for the support of senior clinicians and SA Health in helping students access vaccinations so promptly across all local health networks.

We are also working closely with the Faculty to develop the Bachelor of Medical Studies/ Doctor of Medicine (BMD) program that will replace the MBBS in the coming years.

Another issue on the horizon is the Australian Medical Council's recently released two-year framework for prevocational training, which is slated for implementation in 2023. Students are concerned about how changes may affect their PGY2 year and what it might mean for them.

A big change this year is the format of the Australian Medical Students' Association National Convention. The South Australia-based team is looking forward to providing a great experience for local delegates who can attend and are setting up nodes across the country for those out-of-state to capture the convention magic.

For the AMSS, it does feel as though we are starting to turn a corner and resume many activities that we lost last year due to lockdowns. With clusters continuing to occur across Australia we remain vigilant, with proactive plans for any changes to restrictions, and feel we have a new appreciation for the ability to manage and attend events that we previously took for granted.

'... We are very grateful for the support of senior clinicians and SA Health in helping students access vaccinations so promptly across all local health networks ...'

‘With humility and humour’

Dr John Graham Linn MBBS

1925 – 2021

The character of Dr Graham Linn was evident early on when his final year of medical school coincided with the death of his only sibling Mignon from polio. Despite this he graduated in 1949 from the University of Adelaide, then spent a year at the Royal Adelaide Hospital (RAH) before joining Dr Clifford Jungfer at the Lobethal General Practice.

With roads through the Adelaide Hills long, dusty and windy, and the job of a general practitioner around the clock in the bustling Onkaparinga district, living locally was essential.

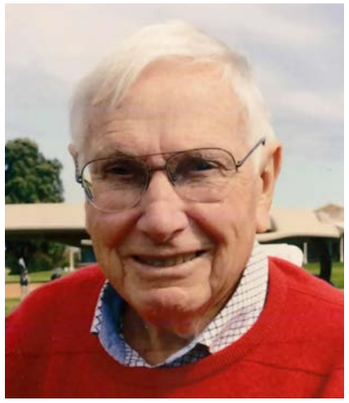
A housing shortage threatened to derail the plans of the newly minted doctor and his fiancée, Nell. They postponed their wedding as Dr Linn scoured the district for a house. In the meantime he was able to reside with Dr and Mrs Jungfer for almost a year, eventually finding suitable accommodation in the Main Street, where they remained until they built their own home overlooking Lobethal.

It was the beginning of an enduring relationship with the Adelaide Hills community, where Dr Linn remained a much-respected doctor until he semi-retired in 1991 after 41 years.

The Onkaparinga Woollen Mill was in a very industrial part of the town and together with the surrounding agriculture and horticulture activity the practice was kept busy with traditional country medicine, obstetrics, broken bones, minor surgery, and constant home visits.

Dr Linn brought compassion and reassurance to his patients with his gentle, thorough manner and keen senses of humility and humour.

Although a ‘city boy’ and the son of a banker, he was well suited to a rural practice (as it was then). He loved the country life and the people it nurtured. He was a knowledgeable and proud



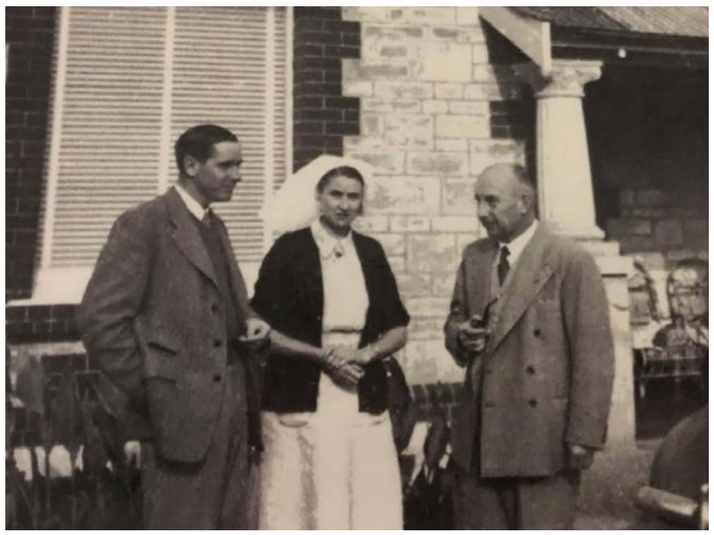
DrJohn Linn

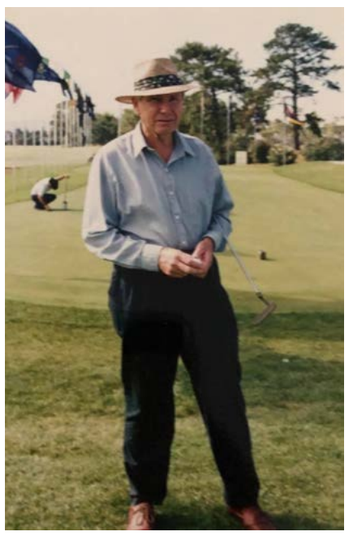
gardener and passionate equestrian who loved his horses. Eventually, a bad fall would turn him toward the golf course for recreation.

In 1991 having moved to suburban Adelaide, he spent his time doing locums and particularly enjoyed being part of the Arkaba Medical Practice. Increasingly, his time was spent on the golf course, with stints as captain and president of the Royal Adelaide Golf Club. He never lost his sense of humour!

Dr Linn retained his membership of the AMA for 66 years. He died aged 95 and is remembered as a noble and generous man. Dr Linn is survived by his wife Nell, three children and three grandchildren.

Nevill Linn





‘With strong convictions’

Dr John Andrew Baird Hokin MBBS, FRCS, FRACS

1936 – 2020

John Hokin was prominent Adelaide plastic surgeon whose career spanned 50 years. He is remembered for his talent as a surgeon, his generosity as a teacher, and his innovative approach making plastic surgery more easily available to patients. In the mid-1990s he pioneered the concept of free-standing day surgeries for plastic surgery in South Australia, saving patients the inconvenience and costs of an overnight stay in hospital.

John was a country boy born in the small South Australian town of Balaclava 90 km north of Adelaide. He was the eldest of four children. Both parents were teachers, which meant the family moved between country towns for several years. He attended Victor Harbor High School and later Adelaide High.

In 1955 John was accepted into the Faculty of Medicine at the University of Adelaide. He had met his future wife Margaret at a school dance the year before. John graduated with the MBBS degree in 1960. In 1961 John headed for an internship at the Royal Hobart Hospital.

John had a Royal Australian Air Force (RAAF) cadetship at university and in return fulfilled a four-year commitment after graduation. Seeking further surgical experience he organised an attachment as surgical registrar to the 3 RAAF Hospital at Richmond, west of Sydney, where he remained from 1962 to 1965.

As well as general surgical duties, he assisted visiting Sydney plastic surgeons Mr Rod Chandler and Mr Basil Riley, took part in aero-medical evacuations, and spent time attached to the South East Asia Treaty Organization in Thailand. The Sydney surgeons encouraged John to further his surgical training in the UK, with an offer of a consultant position in Sydney on his return.

John then spent the years 1966-1968 in Edinburgh. Returning to Sydney in 1969, he took up the promised consultancy at the Royal North Shore Hospital, combining it with a private practice on Macquarie Street and operating at the Ryde and Mona Vale Hospitals. He obtained his Fellowship of the Royal Australasian College of Surgeons (FRACS) in 1971.

After a decade away, John returned to Adelaide in 1971 with Margaret and their three children. He set up a private practice where the patients lived – in the suburbs! He established his practice in Glenelg, becoming the fourth plastic surgeon in Adelaide.

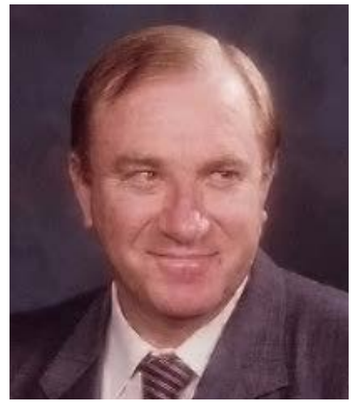
Some years later, John was appointed as the first senior visiting plastic surgeon at the newly established Flinders Medical Centre.

Having set up practice in Glenelg, John came to realise that most of his patients were elderly people and that there was a high demand for skin cancer surgery. He began to treat his patients as ‘day surgery’ patients under local anaesthetic in his rooms rather than in hospital. This became the backbone of his practice, and he established a new trend.

In the mid-1990s John travelled to the US for Ashford Hospital, to learn how day surgery was developing, and came back inspired to help Ashford establish the first day-surgery unit in a South Australian hospital. The original free-standing day surgery model that John set up at Glenelg eventually led to official licensing by the Commonwealth, as South Australia had no power to license day surgeries! Under this arrangement insured patients would be fully rebated, making day surgery financially viable. Glenelg Day Surgery became the first licensed free-standing day surgery in the state.

Patients for major reconstructive and aesthetic surgery requiring an overnight stay were treated at Ashford Private Hospital, where from 1985 to 1996 John was Board member and Chairman of the Medical Advisory Committee. A man of strong convictions, John was instrumental in introducing at Ashford the first hospital ‘no smoking’ policy in South Australia – overcoming energetic opposition from some colleagues.

At Flinders Medical Centre from the early 1980s he collaborated



Dr John Hokin

with Dr Elizabeth Cant in breast reconstruction for breast cancer patients, using the Latissimus Dorsi flap and avoiding where possible the use of an implant. Their work was published in the American Plastic and Reconstructive Surgery Journal.

Along with this demanding clinical and developmental work, John led nine Interplast teams to Fiji and Papua New Guinea between 1986 and 1994. Assisted by colleague surgeons, anaesthetists, and sometimes by his own theatre nurse, he performed life-changing surgery on patients with severe injuries and congenital conditions.

John also served as honorary secretary of the Plastic Surgery Section of the Royal Australasian College of Surgeons in the 1990s.

John travelled widely on professional study tours to the US, Europe and the UK. He also enjoyed travel for pleasure. He was a lover of fine wines and had vineyard interests in the Clare Valley.

John retired from private practice at 73 years of age, after a career spanning 50 years. He was always very supportive of colleagues; his plastic surgery had a personal style influenced by his determination to help patients and achieve efficiency. He nurtured junior colleagues and was very generous in providing consulting space to those young plastic surgeons who had just entered the brave world of private practice. John Hokin always had a definite and decisive way of doing things and he did them well.

John is survived by his wife of 60 years, Margaret, his daughters Frances and Catherine, and his son Michael.

Dr Richard Hamilton MBBS, FRACS

AMA(SA) GALA DINNER

Join friends, colleagues and wider medical fraternity at the 2021 AMA(SA) Gala Dinner on 22 May 2021.

The black-tie event will be staged at the Adelaide Town Hall. Organise a table for what promises to be a wonderful evening, with guest speaker Leigh Sales AM talking about her best-selling book and her experiences as host of the ABC's 7.30 Report in what has been a tumultuous year for politicians, the health sector and the media.

The Gala Dinner will include the handover of the AMA(SA) presidency and vice-presidency. Annual awards will also be presented for outstanding contribution to medicine by an AMA member and for services to medical education.

For more information and updates about the Gala Dinner dinner, please see page 13. For tickets, please go to our website.

NOMINATIONS FOR AMA ROLL OF FELLOWS

The AMA's Federal office is seeking nominations for admission into the Roll of Fellows. After a year in which South Australia did not contribute new Fellows, we hope to nominate worthy contenders this year. Please consider who among your colleagues would be suitable. Nominations, which are strictly confidential and must be in writing, close on 18 June 2021. Please contact Mrs Claudia Baccanello at claudia@amasa.org.au for details.

AMA(SA) ANNUAL GENERAL MEETING

The annual general meeting of AMA(SA) will be held at Level 1, 175 Fullarton Road, Dulwich, at 8 pm on Thursday, 6 May 2021.

More information is available on the AMA(SA) website. Please contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au if you are interested in attending or would like a copy of the agenda.

MAY COUNCIL MEETING

The next meeting of the AMA(SA) Council will be held immediately before the AGM on Thursday, 6 May 2021.

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

DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

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

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

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

PRACTICE NOTICES

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

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

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

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

MEDICAL ITEMS FOR SALE

The following items are for sale:

- AMC 2100 Gynalux couch with footrests, Nautical (dark blue); head-rest cushion. Like new $4,095
- M5 Ultrasound Scan Machine + Array Probe + endocavity probe + Trolley + 5 m orange power cable + carry case. Very good condition $19,096
- Prima GN Colposcope – 6165000-400 over the shoulder. Like new $7,095
- Handheld Doppler with manual. Good condition $175
- 2-drawer steel surgical table. Good condition $400
- Miscellaneous small surgical items, tools, medical supplies, stationery. etc.

If you are interested, please email meikhing08@gmail.com or call 0412 231 400.

FOR SALE

Used MELAG Euroklav 23VS+ Medical Sterilizer Class S autoclave pre-vacuum and vacuum drying plus accessories. 677 cycles. Perfect condition. Practitioner retired. $4,500 ono. Contact 0411 599 544.

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