medicSA

FEBRUARY 2020 VOLUME 33 NUMBER 1

Feeling the burn

GPs offer support and solace to fire-ravaged communities

Health sector prepares for AMA(SA) Culture and Bullying Summit

Virus prompts calls for national response

AMA
SOUTH AUSTRALIA

STATE BUDGET PRIORITY LIST • REMEMBERING OUR FIRST FEMALE PRESIDENT
INFECTIOUS SYPHILIS A RELIC NO MORE • JUNIOR DOCTOR'S BOTSWANAN ELECTIVE

Calvary Adelaide Hospital clinic

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& PARTNERS
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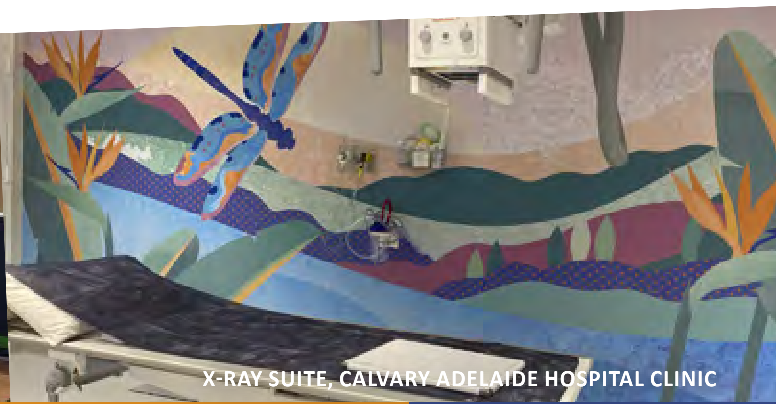
GAWLER CLINIC



X-RAY SUITE, CALVARY ADELAIDE HOSPITAL CLINIC

Contents

'An unmitigated disaster'

Woodside GP Dr Hugh Allen watched as fire burned to his surgery's back door and destroyed the homes and properties of long-time patients.

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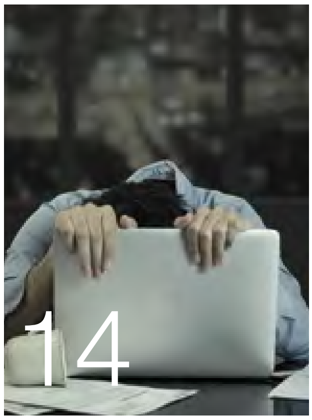


President's report

Dr Chris Moy

Australian doctors at the frontline

As you read this, we will all be two months into 2020 – a new year and a new decade. I have at times been accused of a tendency to being somewhat 'passionate' in entering the fray regarding matters which I think are of importance – certainly this is the criticism levelled by my children when I talk to them as a parent! But I must say, events early this year have been almost overwhelming. The first few weeks of 2020 have thrown at us unprecedented bushfires and the prospect of years of challenging efforts towards recovery. A virus that, as I write this, is threatening to become a global pandemic. And for more and more of us, these events seem to be the very much predicted health impacts of climate change. I wonder what can come next.

But amid chaos there is hope. As Christopher Reeve said, 'Once you choose hope, anything's possible'. In January, as communities across Australia were battling raging fires, other Australians banded together as never before to raise funds, provide goods and services, and to just turn up to give support.

Doctors have been very much at the front line of this effort. Many of those of us with experience in mental health, general practice, burns recovery and other medical fields have found ways to collaborate and support our communities and our members who themselves have been directly affected by the fires. AMA(SA) member Dr Hugh Allen tells his story in this issue; it shows not only that doctors so often become 'the port in a storm' in emergencies, but that this status could be the basis of longer-term recovery efforts.

Also, in January, I met interns at Flinders Medical Centre embarking on the first year of their medical careers. They told me of their nervousness, anxiety and fear – and their joy and excitement. Many are now beginning for real the lives they have dreamed of since childhood. The trick for them will be holding onto these dreams and ideals, which I implored them to do.

These young doctors give me hope. We must not let their spirits be broken by a culture of bullying in health or, worse, to become indoctrinated into becoming bullies themselves. So, for me, the Culture and Bullying Summit we are staging stands as an important moment to say 'this has to stop', and also a time to begin initiatives to create a more positive – perhaps even *happy* – culture in the workplaces where we provide care to our patients.

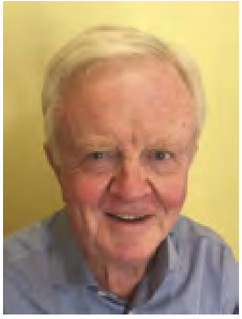
Working with SA Health, GPs and other health practitioners to respond to the coronavirus threat has also reaffirmed my belief that when the going gets tough, we really do try and put aside our differences for the common good. It must be said, however, that the federated nature of the Australian government and the health system makes it more difficult to respond effectively and efficiently as they could to an outbreak such as the COVID-19 virus. Despite the jurisdictions coming together to bring a level of coordination at a national level, individual states have wasted energy on duplicated efforts.

Putting aside our differences

It now seems clear that a national Centre for Disease Control (CDC), which the AMA has been advocating for, would have put the country in a better position to address the current outbreak early – and this might make the difference should we face a more virulent threat in the future.

But, in the end, I choose hope over criticism and cynicism. It was good enough for Christopher Reeve, and he was Superman; later, as a quadriplegic, he raised millions for stem cell research and increased people's awareness of spinal cord injuries around the world. As we move further into 2020 and the decade to come, his kind of hope is a wonderful and precious thing.

... As Christopher Reeve said, 'Once you choose hope, anything's possible' ...



Editor's letter

Dr Philip Harding

As I write this column on our national day, there is good news and bad; and I'm not referring to the invasion rallies as either.

We must all be delighted at the appointment as 2020 Australian of the Year of our member Dr James Muecke, rather remarkably the second South Australian doctor in successive years to be accorded our nation's highest honour. *medicSA* congratulates James, whose achievements and aspirations were featured in our December issue, soon after he was named South Australian of the Year. We hope this additional recognition and national spotlight will help his campaign to raise awareness of, and prevent, diabetes-related and other forms of visual loss.

Likewise, we pay tribute to the five colleagues whose contributions to our profession and the community have been recognised in the Australia Day awards, as detailed on page 17.

Well, that's the yang; what about the yin? A coalition of respected scientists and global leaders recently announced the advancement of the Doomsday Clock to 100 seconds to midnight, the closest point to prediction of annihilation or near-annihilation of the human race since it was established in 1947. They relate this prediction to the increasing incidence of severe climate events – of which we are painfully aware in Australia at present – and to the proliferation of nuclear weapons.

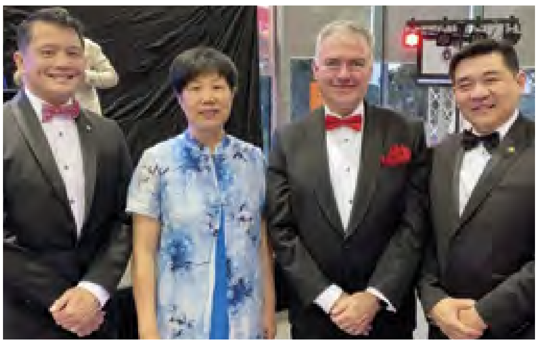
The existence of organisations such as International Physicians for the Prevention of Nuclear War and Doctors for the Environment shows how we, as a profession, have serious concerns about these matters. Doubtless there will still be some sceptics who talk about just another hot summer or hailstorm. But no one can fail to be concerned about the increasing number of countries, some with dubious moral compass or quality of leadership, that already possess or are trying to develop weapons of mass destruction. What we do as individuals I do not know, but it is at least cause for reflection.

Among friends

AMA(SA) Councillors have capitalised on professional meetings and social occasions including the President's Breakfast and the Australian Chinese Medical Association Dinner to share the views of members with local and international officials.

The contribution to the AMA(SA) of former Council Chair David Walsh was recognised at the February Council meeting. Dr Walsh's artwork will be hung in AMA House.

The AMA(SA) will hang Dr David Walsh's painting of an owl in recognition of his service as Chair of the AMA(SA) Council.



AMA(SA) President Dr Chris Moy (left) and Immediate Past President A/Prof William Tam (right) with Health and Wellbeing Minister Stephen Wade and Ms He Lanjing, Consul-General of the People's Republic of China, at the Australian Chinese Medical Association Dinner on 8 February.

Ms Daniela Ciccarello of RACS and Mr Leigh McMahon of Hood Sweeney at the President's Breakfast.

Immediate Past President A/Prof William Tam, former President Dr Janice Fletcher, Dr Nick Vlachoulis and Minister Stephen Wade at the President's Breakfast.

Focus on oral health to avoid broader Indigenous health concerns

Simple policy changes promoted by the AMA will help Indigenous Australians improve their oral health.

Easily implemented, cost-effective policy changes could make a dramatic difference to the poor oral health of Indigenous Australians, according to the AMA's latest 'Indigenous Health Report Card'.

Aboriginal people are twice as likely as non-Indigenous Australians to suffer from dental pain and are five times more likely to have missing teeth due to poor access to dental care, fluoride and oral health promotion.

The report card notes they are more likely to live in areas without fluoride in the water, particularly in Queensland where nearly half of the Aboriginal and Torres Strait Islander population does not have water fluoridation.

AMA President Dr Tony Bartone says that as well as being fundamental to eating well and speaking without pain or embarrassment, oral health is important to prevent illnesses such as rheumatic heart disease and diabetes.

He says Indigenous Australians, like other low socio-economic groups, often struggle to access dental care due to the cost and fear of dental treatment.

'Poor oral health complicates and contributes to other illnesses – illnesses that afflict Aboriginal and Torres Strait Islander Australians at a far greater rate than their non-Indigenous peers,' Dr Bartone says.

'Many Aboriginal and Torres Strait Islander people often rely on public oral health services – where they exist … however, these services can be unsustainable to due to piecemeal, arbitrary and short-term funding.

'As a consequence, a significant proportion of the Indigenous population lives without regular dental care, which has adverse outcomes for their health and wellbeing.

'Governments must ensure that Aboriginal and Torres Strait Islander people have access to affordable, culturally appropriate oral health care programs.'

The AMA suggests an increased focus on value-based health care, particularly preventative measures and culturally appropriate oral health promotion.

The association is calling for a commitment to a national minimum standard of 90 per cent population access to fluoridated water as a safe, effective and equitable way to reduce dental decay.

As well as a focus on oral health promotion, the AMA is proposing a tax on sugar-sweetened beverages, to reduce consumption in Australia which is among the highest in the world.

The AMA's Report Card cites five action areas to improve the oral health of Indigenous Australians:

- fluoridated water supplies – especially in Queensland
- oral health promotion, particularly fluoride varnish programs and a tax on sugar-sweetened beverages
- an effective dental workforce with greater participation of Aboriginal and Torres Strait Islander people
- better coordination and reduced institutional racism in oral health care
- data to know that programs make a difference.

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REPORT

AMA calls for central disease body

The AMA is pointing to unnecessary barriers to effectively responding to the coronavirus outbreak as reasons for a national centre for disease control.

The AMA has renewed its call for a National Centre for Disease Control amid the struggle to contain the spread of the Novel Coronavirus (COVID-19).

AMA President Tony Bartone says Australia has effectively managed the spread of the virus in Australia through strict quarantine measures. However, he says, a national centre could manage future threats in a more coordinated and effective way.

'A National Centre for Disease Control (CDC) would help ensure that everyone's on the same page, and everyone has a real understanding of the networks required to deal with any threats,' Dr Bartone says.

'We are the only country in the OECD that doesn't have such an entity.'

He says the management of recent 'scares' had improved the way information is gathered and shared across Australia. But 'in a world where there are always new threats, new evolving threats, and new evolving transmissions' he says Australia should be better able to manage information and provide coordinated advice.

As of 16 February, Australia had 15 cases of COVID-19: five in Queensland, four in New South Wales, four in Victoria, and two in South Australia.

Internationally, approximately 31,479 cases had been confirmed and 638 deaths reported – a 2.03 per cent fatality rate.

AMA(SA) President Dr Chris Moy says the Federal and state communicable health authorities has worked closely with the AMA and other groups after news of the outbreak reached beyond China, to issue up-to-date information and develop responses and advice.

'I saw first-hand the practical barriers to getting everyone on the same page to work together – such as to develop messaging to all front-line health staff expected to face a large number of potentially infectious patients,' Dr Moy says.

'At this stage, the effort seems have to have been effective. And because of our collaborative efforts, we may have dodged a bullet. But we may not be so lucky next time, if – for example – we face a more virulent agent and a week or two delay might make the difference between threat and disaster.'

He says duplicated efforts at the state and national level slowed response times and prevented valuable resources being available for important prevention and advice tasks.

Dr Moy says the syphilis outbreak in central and northern Australia (discussed on page 27) is an example of the 'appalling' failures caused by the lack of a coordinated response to communicable disease – one he says is due to 'ineptness caused by jurisdictional fragmentation'.

'It is an absolute disgrace that congenital syphilis is becoming prevalent again in Australia,' he says. 'To some degree the Federal Government has been able to get away with this only because the disease has primarily affected our already marginalised Indigenous communities.

'Australia needs a National CDC for conditions such as syphilis and to be better prepared for the next serious virulent viral outbreak, so responses can be fast, decisive, better coordinated and reduce duplication of efforts.'

While he says Australia is behind other nations in not having a national centre for disease control, Dr Moy says Australia is a world leader in the race to develop better testing and a vaccine for COVID-19 – and is the only country outside China to have copied the virus in the lab.

The discovery by Melbourne's Doherty Institute, which was shared with the World Health Organisation, is expected to lead to a test to identify people who may be infected, before they show symptoms.

The virus has been sent to one of Australia's most secure scientific labs, the CSIRO's Australian Animal Health Lab, where scientists will become the first to test and examine the grown virus to learn more about how it is behaving.

In the meantime, Dr Moy says, the AMA and Australia's medical colleges continue to fill the role that should be carried out by a national CDC in coordinating advice to doctors about appropriate reporting and management of suspected cases, and to outline appropriate steps for patients who may have been exposed to the virus.

Country practices the missing link in fire recovery efforts

As a Woodside GP, Dr Hugh Allen watched as fire reached his practice's back door in January. Now he suggests practices such as his should become the hub of health and community recovery services.

Burned landscape near Woodside, and (top right GP Dr Hugh Allen

Just as the Woodside Country Practice was almost on the front line of the Cudlee Creek Fire, it has been at the frontline of the community recovery, providing a salve for everything from burns to broken hearts and dreams.

Situated in the heart of Woodside in the Adelaide Hills, the practice closed on 20 December 2019 and diverted patients to Mount Barker, as the town braced for catastrophic fire conditions. Flames burned almost to the clinic's back door. Yet only a day later, the Woodside Country Practice opened its doors to a community desperately in need of physical and mental help.

For Dr Hugh Allen, originally from Ireland but an Adelaide Hills local now after 22 years in the area, the scale of the Cudlee Creek fire has reinforced the importance of community connections, and of the role of GPs in managing those connections. Dr Allen says he quickly recognised that the practice would become a natural meeting place for people to gather and tell their tales of tragedy and relief; to be 'patched up' with burns dressings before heading out again to fight fires and clear their properties and those of friends and neighbours.

It would make sense, he suggests, for surgeries such as his to become the links between crisis services for people affected by the recent bushfires.

He says he is treating many people who have 'literally lost everything' in the fires. Since the Cudlee Creek fire, there's been a string of patients coming in for five minutes and staying for 30 as they tell their stories. The appointment book is peppered with notes: Patient A, lost house; Patient B, lost farm. They arrive to share stories with practice staff who have their own tales of shock, tragedy and loss.

'We saw many burns patients who would normally have gone to the hospital, and we even ran out of dressings. They were tough Hills people and they refused to go to hospital. They wanted to be out doing what needed to be done – euthanasing their injured animals and fixing fences and things like that. We patched them up and sent them back out there.'

Two months after the fire, many patients are walking in with various levels of post-traumatic stress disorder (PTSD), and will continue to do so for a long time to come.

'We are seeing some very anxious people. Many of them are experiencing something like the stages of grief,' Dr Allen says. 'People I've known for 22 years have lost everything – the fire would have burnt mine too if the wind had been blowing in a different direction.

'The vast majority of people hit are in their 70s – the second and third generations, who have lived in those houses all their lives,' Dr Allen says. 'It's an unmitigated disaster for them. Many will seek assisted accommodation, and many will leave their area, which is very difficult at their stage of life.'

Dr Allen has watched as services have been slow in coming to the people of Woodside. Crisis support – though welcome – seems poorly coordinated and many struggle to access funding and services spread across the public and private sector and non-government organisations. People who have paid insurance premiums for decades are confronting barriers in accessing payouts. He's aware of the increasing anger in the community, along with a realisation of the long and painful reality of having been left with nothing but the clothes they left home with on that haunting, hot and windy Friday in December.

'They [fire victims] have no idea where to start,' he says. 'They are literally starting from the ground up. Their bank details and scripts are gone, and many do not know how to access services.'

Dr Allen says GPs have the knowledge and networks to become 'recovery hubs'; that his practice is 'a natural place for people to come at a time like this'.

'We've been helping people find their way and to make decisions about the next steps,' he says. 'We are in the heart of the town. People would just come in and talk. It was good just to listen. And we could put them in touch with services – we are next door to a real estate agent, for example, organising counselling, re-writing scripts.

'There needs to be some kind of centralised aspect to the relief operations, and it makes sense that general practitioners help in that.'

Warning signs for survivors and first responders

Doctors should be on the lookout for signs of mental-health impacts of the bushfires, says AMA(SA) Vice-President Dr Michelle Atchison.

AMA(SA) Vice-President Dr Michelle Atchison says doctors should be aware of the warning signs that a mental health problem may have developed through exposure to the recent bushfires.

'Whether it is in our patients who have been affected by loss in the bushfire, or in patients who were first responders, we should be aware and look for the warning signs,' says Dr Atchison, a psychiatrist with a special interest in helping survivors of major trauma.

'Right now, most people who have been directly affected by the bushfires will be feeling distressed,' she says. 'But not everyone who is distressed during and immediately after an event such as this goes on to have a mental health problem that requires specific attention.

'In fact, many people use this as a period of growth and show their resilience to stress.'

She says doctors should watch for signals of mental health problems among their patients, including:

- A change in sleep patterns, particularly trouble getting off to sleep and wakefulness during the night. This is usually a sign of heightened anxiety, so that it is harder to relax at night and people come awake more fully between sleep cycles.
- Persistent thoughts or nightmares about what they have experienced. This is normal in the first weeks after a terrible event, but if it is still happening two months later should be considered a 'red flag'.
- Persistently depressed mood or a loss of interest in things that used to be enjoyed. This usually presents as a lack of motivation, finding it harder to engage in life and relationships and a general sense of fatigue. Physical complaints such as breathlessness, chest pain or generalised pain are common.
- Excessive reliance on drugs, including alcohol, to self-medicate anxiety or depression. Another particular form of self-medication that is easier to 'hide' is gambling.

Dr Atchison says there will be mental health services made available over coming months – but those most in need of them may not be ready or able to access them.

'Many of those affected by the bushfires are people who view themselves as strong and independent, and the thought of going to counselling or having medication is likely to be difficult for them,' she says. 'The risks of not treating are high, so please encourage those you identify at risk to have the help they deserve.'

© Blue Razoo

AMA campaigns for GP support

AMA efforts during the summer's bushfire emergencies have ensured Australian doctors will be better equipped to deal with future bushfire emergencies.

Better protocols to deal with emergency services and more resources to help with the ongoing mental and physical impacts of natural and other emergencies are being developed, thanks to the AMA's efforts since mid-December.

AMA President Dr Tony Bartone has raised concerns with Health Minister Greg Hunt about ongoing air quality hazards following the fires, the ongoing mental health impacts for patients and doctors in fire-affected areas, and the need for new emergency management protocols to allow doctors to be involved in crisis responses.

'The AMA has been extensively engaged in responding to both our patients and the wider public's concerns about the impact of hazardous air on individual and population health over the last couple of months," Dr Bartone says.

He says general practitioners treating people in fire-ravaged areas have seen first-hand how people have been affected physically and mentally by ongoing exposure to hazardous air.

While some areas of South Australia had suffered air pollution, the eastern states have suffered prolonged smoke hazard, with Canberra experiencing air quality 22 times worse than the hazardous rating.

Help is available to doctors affected by the crisis who need support for their own health and wellbeing through DRS4DRS.

'Change systems to eliminate bullying'

The AMA(SA) Culture and Bullying Summit's keynote speaker has found systems, not people, are the basis of most workplace bullying.

A risk audit tool designed and tested at the University of South Australia is now being used around the world to identify and rectify the causes of workplace bullying.

Professor Michelle Tuckey of the University of South Australia's Centre for Workplace Excellence has developed the tool after years of increasingly targeted research into the factors that cause bullying in workplaces as diverse as large and small businesses, community service organisations, health workplaces and correctional services facilities.

She says every workplace has a unique mix of the factors that can lead to stress and other issues that directly or indirectly cause bullying. But, she says, it is almost always workplace systems, structures and processes that are the root causes.

'Other approaches – such as bullying awareness training and complaints investigation – focus on the bullying behaviour because that's what's visible. But that's just the tip of the iceberg. My approach is to rectify what's at the bottom of the iceberg,' she says.

Professor Tuckey is the keynote speaker at the AMA(SA) Culture and Bullying Summit on 29 February. Her presentation will demonstrate that hospitals and other health workplaces are not unique in having bullying and harassment issues.

When she joined UniSA in 2005, Dr Tuckey's focus was work and well-being. She became interested in workplace bullying and the stress that bullying generates, which led to more targeted questions about the risk management of bullying: how can organisations improve their culture and results if they identify and remove bullying from their workplaces through systematic risk controls?

It was a question few were asking; even now, few academics around the world are exploring it. 'Bullying is clearly erosive to health and well-being – I wanted to uncover something new that could change what we can do about it,' she says.

An examination of 342 complaints lodged with SafeWorkSA from a variety of workplaces and sectors generated about 5,500 pages of data. The analysis provided new evidence of the structures and processes that lead people to feel they have been bullied in their workplaces.

'We identified how bullying manifests through the way work is designed,' Professor Tuckey says. 'By discovering what the risk factors are, we can focus on them and introduce solutions.'

Professor Michelle Tuckey

Six further studies have finetuned the original results. Professor Tuckey and her team have also demonstrated the extent to which bullying does corrode culture and performance in a wide range of industries and workplaces. It led to the development of a 'risk audit tool' now being used around the world.

The online risk audit tool identifies the social and organisational factors that employees identify as being present in their workplace. It highlights hot spots for bullying, stress, and other threats to the mental health of workers, providing guidance for solutions customised to that workplace, unit and team.

'The tool pinpoints where risk control interventions can be introduced to support their workers' mental health and wellbeing and build a mentally healthy workplace,' Professor Tuckey says. 'For example, in our validation work we showed that the risk assessment tool can discriminate between high-, medium- and low-risk hospital wards, based on independent outcome data.

The Risk Audit Tool assesses 10 groups of factors

- Working hours, rostering and scheduling – how work shifts are rostered and how hours of work are assigned
- Leave and entitlements – how employee leave and breaks are allocated and managed
- Job roles – the assignment of employee job roles and the clarity of information about job descriptions, responsibilities and expectations
- Under-performance – how issues of employee under-performance are addressed
- Training and professional development – identification of staff training needs, and the provision of learning, coaching and mentoring opportunities
- Appraising and rewarding job performance – how performance is evaluated and how employees receive feedback, recognition and rewards
- Promoting mental health and wellbeing – what activities are present or available to promote and protect workers' mental health and wellbeing, and to reduce risks to mental health
- Tasks and workload – how work resources are managed, and tasks and workloads are allocated and coordinated
- Maintaining a safe working environment – what activities are present or available to assess and manage physical safety hazards
- Interpersonal and team relationships – how employees are treated individually and coordinated in the work unit, through communication, participatory decision-making, and personal concern and support

'What we see is that the risk assessment tool provides a good overview of the risks. And it resonates with staff – they get it. The intervention process involves staff and management at all levels, with everyone working together on solutions. That collaboration is very powerful. Everyone has a voice, and it gives everyone hope.'

Eventually, she says, 'we can get to a set of actions that changes the way the workplace functions, reduces stress, and limits the possibility of bullying'.

'There are identifiable types of workplaces where it is likely to happen – places where their systems, design and pressures have been shown to be a breeding ground for stress,' Professor Tuckey says.

'But we work with people to find the right solutions. Some can start the very next week – for example, it may be changing the way information is managed and shared. Other actions may take a year or more – such as changing the management structure or establishing leadership development programs.'

Now, Professor Tuckey is being approached by businesses and governments around the world interested in her audit tool.

'We find bullying everywhere,' Professor Tuckey says. 'But there are things about health systems – the way they're structured, with not enough resources, with hierarchy and the tension between aiming for optimal patient safety and the health and wellbeing of people in the workforce – that make them among the workplaces with the highest risk of it occurring.'

Professor Tuckey says the introduction of a new governance structure – such as the new Local Health Network boards introduced in South Australia last year – provides an ideal opportunity for change. She says the evidence shows that monitoring and evaluating risk factors, and having performance on such indicators included in board evaluations, helps drive meaningful change in bullying prevention.

Solutions needed to stop systemic bullying

The AMA(SA) Culture and Bullying Summit aims to address the many impacts of bullying on doctors and patients.

The impacts of bullying in health workplaces on doctors and health practitioners, and the measurable effect on their capacity to care for their patients, will be a major focus of the AMA(SA) Culture and Bullying Summit on 29 February.

AMA(SA) President Dr Chris Moy says Health and Wellbeing Minister Stephen Wade's agreement to speak at the Summit demonstrates the sector-wide recognition that bullying and harassment are issues that must be addressed.

Minister Wade and representatives of Doctors Health SA, the AMA(SA) Doctors in Training Committee, the Royal Australasian College of Surgeons, and the Health Consumers Alliance of SA are among speakers and panellists at the Summit, to be staged at the University of Adelaide.

Dr Moy says keynote speaker Professor Michelle Tuckey will discuss her research findings that the root causes of workplace bullying are often organisational structure and process issues.

He says doctors forced to work in environments where bullying is not 'called out' are likely to suffer stress and other mental health effects that influence their capacity to provide best-quality care.

'This Summit has attracted representatives from across the health sector,' he says. 'We all know things have to change, and we all want to identify and be part of solutions that recognise the variety of triggers and experiences in different workplaces.'

A report with recommendations for action will be submitted to Minister Wade after the summit.

South Australians earn national accolades

Australian of the Year Dr James Muecke heads the list of South Australian doctors recognised in the 2020 Australia Day Honours List.

The Australian Medical Association was pleased to congratulate long-time member Dr James Muecke AM of Norwood when he was named Australian of the Year last month.

Ophthalmologist Dr Muecke has spent his medical career fighting blindness in Australia and internationally, and is a strong campaigner to raise awareness of type 2 diabetes, a leading cause of blindness in adults.

Dr Muecke was one of a number of medical practitioners honoured in the Australia Day Honours list, including Senior Australian of the Year Dr John Newnham of Perth.

Dr Muecke was recognised for his work in founding the Vision Myanmar Program, a $1 million initiative of the South Australian Institute of Ophthalmology, which developed and operated health and blindness projects in Myanmar.

He also co-founded Sight for All, which raises funds to treat and prevent blindness in low-income nations. Dr Muecke donates more than 40 hours of his time and expertise each week to Sight for All.

Dr Moy congratulated Dr Muecke, along with all AMA members and other medical practitioners, for awards he said recognised the care and services many doctors provided 'above and beyond' for patients and communities at home and around the world.

'James is a dedicated doctor who has shared his knowledge and expertise to help patients, doctors and students,' Dr Moy said.

'He is a role model in demonstrating that many of us have opportunities to do more and give more.

'Immediately upon being named South Australia's nominee as Australian of the Year in November, and again when announced as Australian of the Year, James promised to use his time in the spotlight to shed light on the growing threat of diabetes and its impacts.

'The AMA(SA) Council and our members will help James however we can to spread the word about how the scourge of diabetes, which now affects more than one million Australians, can lead to a terrible loss of sight.'

Dr Newnham is a world-renowned obstetrics specialist who has made Western Australia a global centre for research and clinical excellence in pregnancy and life before birth. His research has unravelled many of the mysteries of life before birth, how health and disease throughout our lifespan may result from pre-birth events, and how common illnesses and disabilities can be prevented during pregnancy.

In South Australia, **Dr Edward (Ted) Tuckseng Mah** received the Public Service Medal (PSM) for outstanding public service to public health in South Australia for more than 25 years. Dr Mah was a faculty member in Flinders University's College of Medicine and Public Health and in 2019 he received the AMA(SA) Award for Outstanding Service in Medicine for his tireless work in teaching research in and the practice of orthopaedic surgery.

Dr Walter John Russell OAM is a life member of the AMA(SA). He was a long-serving member of the anaesthetics department at the Royal Adelaide Hospital, recognised for his research into the causes and prevention of hypersensitivity reactions to anaesthetics.

During his career, Dr Russell became known as a bioengineer as well as an anaesthetist. His development of anaesthetic syringe labelling and colour-coding is now included in international requirements.

Other South Australian medical practitioners honoured in this year's list include endocrinologist and medical educator **Dr Sanghamitra Guha AM**, Quorn GP **Dr Anthony Lian-Lloyd OAM**, gynaecologist **Dr Ken Rollond OAM**, Wakefield Orthopaedic Clinic orthopaedic consultant **Dr David Marshall OAM**, and cardiologist **Dr Sadanand Limaye OAM**.

Dr James Muecke

Professor Ted Mah

Dr Shriram Nath Councillor

AMA(SA) Council Meeting February 2020

The AMA(SA) Council starts the year with a new Chair.

Vice-President Dr Michelle Atchison was elected unopposed into the position made vacant when Dr David Walsh resigned as Chair.

Dr Walsh's period will be remembered for many reasons – not least his painting of an owl, *Are You Looking At Me?*, which AMA(SA) President Dr Chris Moy bought as a mark of respect and thanks at the recent Royal Australian College of Surgeons (RACS) Charity Dinner. Dr Moy has donated the painting to the AMA(SA) and it is to be hung as a mark of appreciation for Dr Walsh's years of service as Chair.

Dr Moy urged Councillors to attend the AMA(SA) Culture and Bullying Summit to be staged on 29 February.

Doctors in Training (DiT) representative Dr Hannah Szewczyk said she will discuss the results of the DiTs' South Australian Hospital Health Check at the Summit, and pointed out that recently released AMA data will provide a national perspective on the issue.

Councillors highlighted the impact of the bushfires that have devastated so much of Australia over the summer on doctors, patients and communities. It was suggested that practical and sustainable measures to embed the climate effects of health into public policy are the most effective approach– and that the AMA is a solution-based group that can (and should) lead the discussion, because of the links between climate change and health.

How the AMA(SA) can best support medical practitioners in bushfire-affected areas was discussed. The rollercoaster nature of the season's weather was highlighted when discussion of the fires turned to the floods that affected 75 per cent of the Port Lincoln Hospital.

AMA(SA) Vice-President and new Council Chair Dr Michelle Atchison and President Dr Chris Moy thanked Dr David Walsh for his service as Chair, at the February meeting.

The looming threat of COVID-19 was a timely issue, as was the important role of the AMA in South Australia and elsewhere in developing and disseminating factual, practical advice to doctors and patients. Dr Moy said Health and Wellbeing Minister Stephen Wade and senior SA Health officials had relied on the AMA(SA) for support and guidance.

Councillors expressed significant concern that the rural GP training positions, along with the generalist program, did not attract enough candidates. Dr Moy reinforced the work the AMA is doing locally and nationally to advocate for increased resourcing for health in rural areas, and to improve the image and appeal of rural practice.

ADVOCACY

Changing of the guard

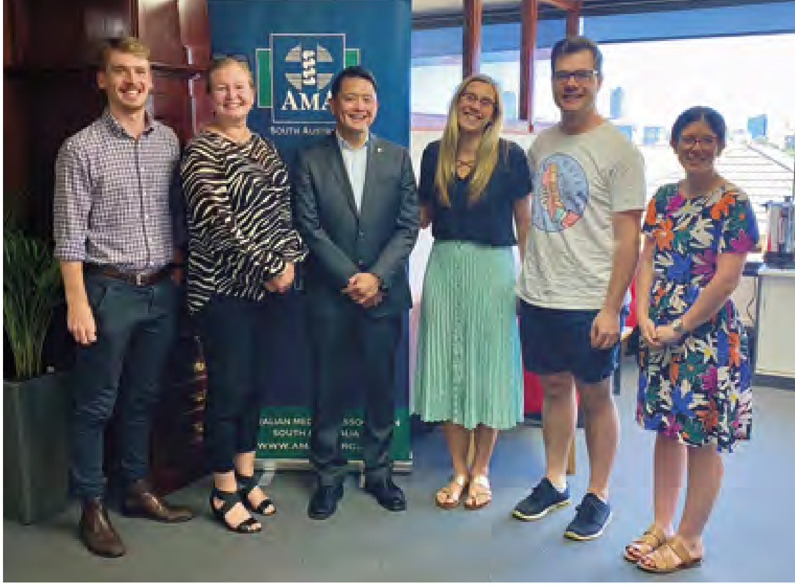
AMA(SA) President Dr Chris Moy took an opportunity in the holiday season to thank the AMA(SA) Council's 2019 student representatives for their contributions during a busy year.

Dr Diana Hancock and Patrick Kennewell represented Flinders and Adelaide universities respectively.

'During their 12 months on Council, Diana and Patrick participated in important discussions and decisions about issues ranging from abortion law reform to end-of-life care legislation, from how we should advise the South Australian Government about planning the new Women's and Children's Hospital to ensuring our rural colleagues receive the funding and support they need,' Dr Moy said.

'It is critical that our Council represents the diverse groups within our membership and within the medical profession. I hope Patrick and Diana have also benefited from the experience, and that we can look forward to them continuing to bring their knowledge and experience to the AMA(SA).'

The Council welcomed its new student members, Matilda Smale from Flinders University and the University of Adelaide's Jack Rumbelow, at its first 2020 meeting on 6 February.



New Councillors Jack Rumbelow (far left) and Matilda Smale (far right) with CEO Dr Samantha Mead, Dr Chris Moy, Dr Diana Hancock and Patrick Kennewell

AMA(SA) submits big-ticket items for State Budget

Rural health is among the items the AMA(SA) has identified as needing a large injection of funds in the 2020-21 Budget.

The AMA(SA) has reinforced to the State Government that increased funding for rural and regional health staff and services, and for mental health services, is urgently needed if South Australians across the state are to receive quality care.

AMA(SA) President Dr Chris Moy and Council identified the major issues that the AMA considers require dedicated State Government funding and attention in the 2020-21 Budget.

'I have sought the input of our Council, which has among its members representatives of general practice – including rural general practice – other medical specialties, doctors in training and South Australia's two medical school student bodies,' Dr Moy wrote.

He said the priorities 'are provided in the hope they will guide the allocation of funding to health and wellbeing infrastructure, programs and services, so that our state's health system is best placed to provide quality care to all South Australians'.

Dr Moy said the suggestions were essential 'investments in the immediate and long-term health of the community we all serve'. A summary of the priorities and the Council's reason for their inclusion is provided below.

1. Rural and regional health, including support of rural general practitioners, resident specialists, and pathways to encourage junior doctors to enter rural general practice

The AMA(SA) believes the draft 'Rural Medical Workforce Plan' must be backed by adequate funding and implemented in a new, improved spirit of cooperation with general practitioners (GPs) and other specialists who form the core of the rural medical workforce.

The 10 issues of most concern to rural GPs, as identified in their feedback to the *2019 AMA Rural Health Issues Survey*, included:

- the need for extra funding and resources to boost staffing levels at rural hospitals
- encouraging medical colleges to include rural rotations for trainees to rural areas
- ensuring rural hospitals have modern facilities and equipment
- access to high-speed broadband for medical practices
- more support for training of junior doctors in rural areas.

2. Public hospitals, including the RAH and the new Women's and Children's Hospital

'This state needs an evidence-based, clinician-led health system that puts people first,' Dr Moy wrote. 'Buildings such as the new Women's and Children's Hospital (WCH) must be designed and developed in consultation with the AMA(SA) and other clinicians' bodies, to ensure they are best placed to offer those services and address the needs of patients, doctors and health practitioners, and other users.'

He said funding was needed for 'neglected work' in the health system, including a Comprehensive Childhood Health Plan for South Australia.

3. Mental health services

The AMA(SA) called for significant investment in mental health services, including in psychiatric beds. Dr Moy said South Australia has 32 psychiatric beds – 27 public and five private – per 100,000 residents, compared to the Australian average of 42 beds per 100,000 population.

The AMA(SA) also calls for state-based support for measures outlined in the *National Suicide Prevention Plan*.

4. Implementation of the outcomes of the AMA(SA) Culture and Bullying Summit

The AMA(SA) Culture and Bullying Summit on 29 February 2020 will generate recommendations for action to be presented to the Minister for Health and Wellbeing. The AMA(SA) asked that funds be allocated to implement the recommendations, which will aim to improve working conditions for doctors and other health practitioners, the health and wellbeing of those doctors and health practitioners, and the safety of patients.

5. Funding for palliative care and Advance Care Directives promotion and education

'Professor Wendy Lacey's review of the *Advance Care Directives Act 2013* laid bare the lack of understanding in the community and among health practitioners of Advance Care Directives (ACDs) and the key role they play in protecting the self-determination of patients who have lost decision-making capacity, especially at end of life,' Dr Moy wrote. 'This has been due to totally inadequate levels of funding for the promotion of ACDs and education about their use among individuals and health practitioners.

'The South Australian Government may be considering the introduction of voluntary assisted dying (VAD), but any debate about VAD must not ignore the importance of the palliative care services sought by 98 per cent of patients at the end of their lives, even if VAD comes into effect.'

6. Clinician-led research and creation of an independent data analytics unit

Funding is required to continue cutting-edge, clinician-led research at our teaching hospitals and research institutes, to advance investigations and treatments, including precision medicine, and maintain South Australia's nation-leading status.

A clinical data analytics unit is needed that is 'transparent and run independently of SA Health so there can be no accusations of bias'.

7. Funding of advance trainee positions

The AMA(SA) believe that funding for the adequate numbers of advance specialist trainee positions in South Australian public hospitals must be a priority.

While there is extensive, urgent national (National Medical Workforce Strategy) and local (Rural Medical Workforce Plan) work to be done to overcome the gaps in knowledge and future planning for the medical workforce, there is also a need to maintain and increase advance specialist training positions. Dr Moy said a failure to do so will risk losing specialists to interstate hospitals and increase service gaps in South Australia.

Evidence-based advocacy

The AMA(SA) has provided feedback recently to governments and other entities on topics ranging from child safety to the use of restraint in mental health services in recent months.

Submissions to SA Health, Health and Wellbeing Minister Stephen Wade, Child Protection Minister Rachel Sanderson and other organisations have emphasised that the AMA(SA) is the peak body for South Australian doctors and the entity best placed to offer evidence-based opinions to influence health-related policy and decision-making.

In addition to its State Budget priorities, the AMA(SA) provided input and feedback relating to the following in December and January:

- a request from Child Protection Minister Rachel Sanderson about the operation of the *Children and Young People (Safety) Act 2017*
- Chief Psychiatrist Dr John Brayley's request for a response to the draft standard that would eliminate the use of restraint and seclusion in mental health services
- an invitation to provide input to the inquiry being conducted by the Australian Government's Parliamentary Joint Committee on Law Enforcement in relation to the value and efficacy of public communications campaigns targeting drugs and substance abuse
- support for the AMA(SA) Committee of General Practice in contacting GPs for comment on the 10-year Primary Health Care Plan Framework.

The AMA(SA) recognises the value of working with key partners to inform advocacy positions and improve the health and well-being of South Australians.

Dr Moy has been working closely with Chief Public Health Officer Associate Professor Nicola Spurrier and her colleagues to develop accurate, up-to-date information and resources about South Australia's response to COVID-19. The information has been shared with members on the AMA(SA) website and through SA Health digital media.

Australian health system at tipping point - AMA

The AMA is calling on the Australian Government to significantly increase recurrent spending on health to properly meet current and future demand for quality care and services in the Australian health system.

Releasing the AMA's pre-Budget submission for the 2020-21 Federal Budget, AMA President Dr Tony Bartone said the AMA wants the Australian Government to lift spending from its current level of 9.3 per cent to a level in line with comparable countries.

He said the Australian health system is 'facing a funding crisis'.

'We are at the tipping point,' Dr Bartone said. 'The cornerstone of our health system is general practice.

'The role of primary care, especially general practice, must be built up and properly supported to underpin and coordinate service provision across the whole health system. (But it has been) under-resourced and underfunded for more than a decade. Our public hospitals are underfunded and operating beyond capacity. And despite recent reforms, private health insurance still lacks value and affordability … and the confidence and trust of consumers.'

Dr Bartone said the aged care sector was 'in turmoil' and mental health services were desperately in need of more, strategically targeted, funding.

In addition, he said, Australia needs 'a renewed and reinvigorated focus on preventive health'.

'We need people to be fitter and taking responsibility to make better lifestyle choices to keep themselves healthier and out of hospital. This will need considerable new funding and a coordinated approach from all governments at all levels of government – Federal, State, and local.

'The inescapable facts are that Australia's population is growing, people are living longer, and the incidence of chronic and complex health conditions is expanding significantly. Keeping people healthy and active will require funding – significant new funding.'

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Training needs more GP content

Dr Penny Need

Doctor training programs need a radical re-think to give trainees a chance to try – and love – general practice, particularly in the rural areas, says Deputy Chair of the AMA(SA) Council of General Practice and GPEx Senior Medical Educator, Dr Penny Need.

Dr Need says only half of South Australia's rural GP trainee positions have been filled this year due to lack of interest, compounding an already dire situation in rural health.

GPEx is the South Australian training organisation for doctors specialising in general practice.

While there is a joint SA Health and GPEx study – the Medical Specialty Decision Making Research Project – to determine drivers of this lack of interest, Dr Need believes the main reason is that students and junior doctors no longer receive enough exposure to general practice during their training.

Whereas there were 197 junior doctors in South Australia who undertook rural rotations under the former, federally funded, Prevocational General Practice Placements Program (PGPPP), the Rural Doctors Workforce Agency now includes just 20 rotations.

There are also 12 rural intern positions that started in 2019 and some additional rural resident medical officer positions are likely to start soon.

'It is a downward trend nation-wide, but this is the first year we didn't even fill our general spots,' Dr Need says. 'It's looking a bit dire for GP training, considering that registrars make up 25 per cent of the rural workforce historically.

'There is also very limited exposure in both of the (medical) schools in South Australia now – it seems to be getting less and less.'

She says this limited exposure denies junior doctors – most of whom hail from city backgrounds – the opportunity to experience life as rural GPs. In addition to increasing the number of junior doctors who opt for general practice and rural practice, she says having all junior doctors include rural practice in their training would give those who choose careers as surgeons and specialists more knowledge to care for the patients referred to them or who they treat in emergency situations.

'Unless you experience general practice, you really don't know what it is all about,' Dr Need says.

'General practice is amazing, and rural general practice is particularly fantastic, but you need to experience it to know.

'My personal opinion is that every intern should do a rural general practice rotation or a general practice term, just as they have to do an emergency term and a surgery term.

'That would produce better doctors across the board. We're all going to communicate better together if we know a bit about what each other does.'

Dr Need said there was capacity and willingness among general practices to take students, but this needed to be adequately funded so junior doctors can access Medicare rebates for their services, rather than being solely supported by small businesses.

... 'We urgently need to bring back more prevocational exposure in general practice for junior doctors' ...

Equally, she says, the training coordination needs to be adequately supported. Dr Need points out that the PGPPP was supported to ensure quality training, practice accreditation and to organise placements; the new federal program to attract rural doctors is not.

Dr Need says general practice had recently had 'a bad rap', with the perception that it was poorly remunerated and over-corporatised. But, she says, many of the students and junior doctors who try it become enthusiastic advocates, attracted to the variety of work, the ability to set their hours, the diagnostic challenges and the opportunity to 'see cases through'.

'Junior doctors and students who go out rurally get to do a lot more than they would sitting at the back of a ward round in the hospital,' she says. 'There is a breadth of opportunity untapped out there in the rural space.'

'This is a people-facing profession and (in general practice) you build relationships over time,' Dr Need says. 'You do become the trusted source of clinical information and a go-to person for them and coordinator of care. It's nice to be that for them.

'It's being part of their story ... I can't quite explain how meaningful it is. Seeing the little people grow into adults and being part of their lives is really good.

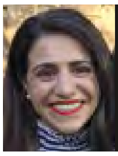
'There's less hierarchical pressure than many other areas of medicine. It's a very friendly culture – once you are in GP training, you are a colleague.'

GPEx, the AMA and AMA(SA) are working to raise the profile of general practice, to expose students to it, and to help trainees prepare for the rigorous exams set by the Royal Australian College of General Practice – for which the pass rate for one of the written segments is only 55 per cent – and the Australian College of Rural and Remote Medicine exams, with a 30-40 per cent pass rate for the clinical assessment.

GPEx and the AMA(SA) are in discussions with the Deans of the Adelaide and Flinders Medical Schools to highlight the importance of general practice.

GPEx is also undertaking a hospital engagement initiative in partnership with the Local Health Networks, aiming to increase awareness of what a career in general practice can offer. It is also promoting general practice training through social media.

'Once people do it, they love it,' Dr Need says. 'We have fabulous trainees – we just need more.'



JADE PISANIELLO
STUDENT NEWS:
ADELAIDE UNIVERSITY

Although medical school examinations might be long forgotten for many reading this, or perhaps the memories of the silent depths of the Barr Smith Library have been repressed, the Class of 2020 recently breathed a sigh of relief (as did many parents) after we passed our exit examinations at the conclusion of fifth year in 2019. Congratulations to all of the new sixth years. I hope that we will demonstrate leadership and generosity of spirit to our junior students throughout the year.

This year marks 131 years since the inception of our society. The AMSS has evolved a great deal over the years, but the more things change, the more they stay the same. The AMSS continues to host a variety of educational and social events, among which some are new and some well-established: 2020 will see the (in)famous *Skullduggery* orientation week party return to the grounds of the university for the first time since 1995, the Australian Medical Students' Association's *National Convention* will convene in Melbourne, and the first-year students will be welcomed to the AMSS at Normanville as part of our annual *MedCamp* over the March long weekend.

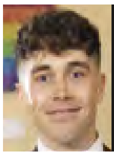
While some of our events are steeped in tradition, we continue to strive to improve inclusivity and celebrate minority groups within the AMSS. Since its inception in 1889, the AMSS as had 116 male and just 14 female presidents. In late 2019, I was elected as the 15th female president. I will fulfil this role alongside an incredible executive committee which is itself three-quarters female. In November 2019, our members marched for the first time in the annual *Pride March* which celebrates Adelaide's LGBTQIA+ community. Although we have a long way to go, we have certainly made great strides and are looking forward to continuing to promote diversity within our student body.

We'll be focusing on guiding and supporting students during the changing of the medical program structure from MBBS in 2020 to MD in 2021, in addition to continuing to deliver a robust educational and social calendar. We want to maintain our status as one of the most active medical student societies in the country.

The 2020 AMSS Executive committee

I write to you eight floors up from the picturesque library overlooking North Terrace at the Royal Adelaide Hospital, but many of my classmates are fulfilling international electives all over the world - from rural sites across South Australia, Nepal, Vanuatu and everywhere in between. Our society prides itself on a unique culture of solidarity and camaraderie. No matter where in the world you find yourself, whether it be as a student or an alumni, an AMSS member is never far away.

Curiouser and curiouser



LIAM RAMSEY
STUDENT NEWS:
FLINDERS UNIVERSITY

I was recently asked by an ENT professor if I knew what the term 'doctor' meant. 'Doctor' is now an academic title, but in its Latin origin it is an agentive noun of the Latin verb docēre, meaning 'to teach'.

Doctors are multi-faceted professionals; our fingers are figuratively covered in different types of honey. But do we dive into the honey pot that is so fundamental to our title 'doctor'? We care for vulnerable people, we advocate for the marginalised, we research for the masses, but do we teach our own?

Teaching is a special skill. It is crucial to the development of all stages from student to junior doctor to consultant. The literature reflects that senior clinician mentorship is central to medical students being able to model professional behaviour and that it significantly influences the career trajectory of students. We know medical students want engagement with senior doctors, but is this reciprocated?

The literature reflects that doctors want to teach. It suggests their principal motivator is altruistic, making the next generation of doctors safer patient advocates, and being able to pass knowledge and experiences they wish they knew in their junior years. Simultaneously, it fosters interest and promotes their speciality.

However, the clinical ecosystem does not always permit this altruistic behaviour. Student numbers have steadily grown, and consultants are expected to teach and supervise more students than previously. The apprenticeship model is changing to one of a mini-series of lectures on ward rounds, at bedsides and in doctors' offices. The smaller-group teaching that can adapt to the learning style of the individual students is unfortunately now lacking.

Excessive clinical workload impedes clinical teaching and mentorship. Senior doctors want to teach, but patients must be the No.1 priority. Students also have to want to learn. Academic curiosity is regarded as a desirable trait. But the more schools include in a curriculum, the more you bludgeon this curiosity as students strain to survive.

Medical schools select and train doctors. Being clinical mentors is simply a pragmatic after-thought of the profession. Educational pedagogy isn't a core part of course curriculums, but doctors are 'to teach'. Recent doctor training at the University of Sydney headed by Dr Foster and Dr Laurent demonstrated that when doctors are supported and given evidence-based teaching in medical education they feel more prepared to teach in a meaningful way and require less support to teach.

With this in mind, let's encourage student curiosity in a range of specialities. Let's create a culture that digresses from hierarchy and emphasises connectedness. Let's get back to the roots of what it means to be a doctor: to teach.

Syphilis returns as a threat

The return of syphilis is worrying doctors and governments across Australia, write SA Health's Holly Skene and Dr Brendan Kennedy.

Syphilis, a notifiable sexually transmissible infection (STI) caused by *Treponema pallidum*, was once rarely seen and was close to being eliminated in remote communities in Australia. It is thought of by many as a relic of the past, bringing to mind images of Henry VIII and wartime posters about venereal disease.

However, far from being a relic, infectious syphilis has made a comeback, primarily in urban men who have sex with men, and in younger rural and remote Aboriginal and Torres Strait Islander peoples. Infectious syphilis (which can occur during the two years following infection) carries significant health risks, particularly during pregnancy, and increases the risk of HIV transmission. Currently there is an outbreak affecting predominantly rural and remote Aboriginal and Torres Strait Islander communities in northern Australia. First declared in 2011 in northern Queensland, the outbreak has since expanded to the Northern Territory (NT) and Western Australia (WA), and into South Australia (SA) in the Far North, Eyre and Western, and Adelaide regions.

This outbreak, which has been described by many as a case study of public health failure, has so far led to the death of seven infants amid 16 cases of congenital syphilis.

OUTBREAK EPIDEMIOLOGY

From 2011 to 30 November 2019 there were 3,224 infectious syphilis cases related to this outbreak reported in Australia; 1,494 in Queensland (from January 2011), 1,215 in the NT (from July 2013), 420 in WA (from June 2014) and 95 in SA (from November 2016).

Source: https://www1.health.gov.au/internet/main/publishing.nsf/Content/71E8A32E7518E532CA25801A0009A217/$File/21-Surveil-Report-Dec19.pdf

In SA, approximately half (48 per cent) of all cases have been among young people aged 15-29 years, compared with between 61 and 70 per cent in other states, with 55 per cent men and 45 per cent women. Six cases have been diagnosed in pregnant women with one confirmed case of congenital syphilis that was treated successfully. While most SA cases have been reported in the rural and remote regions of the Far North (58 per cent) and Eyre and Western (5 per cent), the proportion of cases occurring in Adelaide (37 per cent) is increasing, accounting for 70 per cent of cases since January 2019. Nationally, Adelaide is the largest city included in the outbreak.

... This outbreak, which has been described by many as a case study of public health failure, has so far led to the death of seven infants and amid 16 cases of congenital syphilis ...

Overall, the outbreak has affected young, heterosexual and remote Aboriginal and Torres Strait Islander communities. However, in Adelaide, 25 cases (71 per cent) have occurred in men, including 11 identifying as men having sex with men and two reporting sex with men and women.

SYPHILIS IN PREGNANCY

Transmission of syphilis during pregnancy can lead to perinatal death, premature delivery and congenital abnormalities.

The 'SA Perinatal Practice Guideline: Syphilis in Pregnancy' has been updated to reflect the importance of repeat testing during the antenatal and postnatal period in the context of an outbreak. Routine screening should be offered at every first antenatal appointment (12-14 weeks). For Aboriginal and Torres Strait Islander women (or partners of Aboriginal and Torres Strait Islander men) residing in, or travelling to or from an outbreak affected area, additional screening is recommended at 28 weeks, 36 weeks, at birth, and at the six-week post-natal check.

Treatment should occur as soon as possible and ideally 30 days before delivery. For women suspected of having syphilis who live in outbreak areas, treatment may need to be given before confirming results.

THE OUTBREAK RESPONSE

The Communicable Disease Network of Australia and the Australian Health Protection Principal Committee are coordinating and overseeing efforts in conjunction with jurisdictions to curtail outbreaks. In SA, a Syphilis Outbreak Working Group comprised of government, non-government, Aboriginal Community Controlled Health Services (ACCHS) and sexual health stakeholders has developed a Syphilis Outbreak Response Plan. The plan has been endorsed by the Minister for Health and Wellbeing and focusses on antenatal and postnatal care; prevention, education and community engagement; workforce development; testing, treatment and partner notification; and surveillance and reporting.

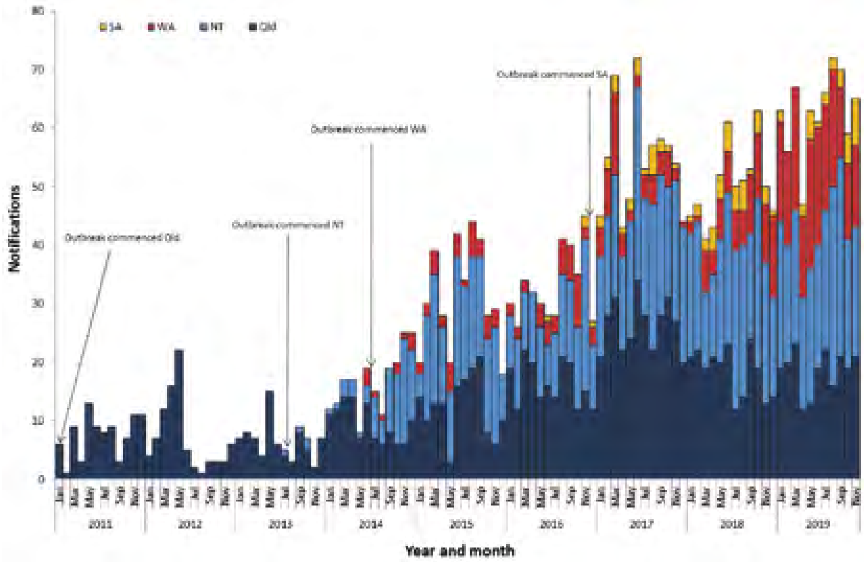
Projects under way include the Young Deadly Free health promotion campaign, workforce development, and the roll out of dedicated sexual health positions in outbreak affected areas.

SA SYPHILIS REGISTER

Accurate staging and interpretation of syphilis testing requires a history of the patient's illness, including any previous test results and treatment. In response to the outbreak, the Communicable Disease Control Branch (CDCB) is establishing a syphilis register to help healthcare workers interpret results in cases in Aboriginal and Torres Strait Islander people, to assist healthcare workers in interpreting test results, and provide advice on treatment and assist with contact tracing.

KEY MESSAGES

- Infectious syphilis is increasing across Australia, particularly among urban men who have sex with men and in rural and remote Aboriginal and Torres Strait Islander communities.
- There is a multi-jurisdictional syphilis outbreak active across northern Australia, including in the Far North, Eyre and Western, and Adelaide regions of SA.



Infectious syphilis outbreak cases notified in Aboriginal and Torres Strait Islander people in affected regions, January 2011 to 30 September 2019

- For pregnant women at risk, increased syphilis screening is recommended at first visit (12-14 weeks), 28 weeks, 36 weeks, at birth, and six weeks post-natal.
- The SA Syphilis Register is being established for cases in Aboriginal and Torres Strait Islander people, and to help healthcare workers interpret test results, provide advice on treatment and assist with contact tracing.

Ms Holley Skene is Senior Project Officer HIV and STI in SA Health's Communicable Disease Control Branch. Dr Brendan Kennedy is an infectious diseases physician in the Communicable Disease Control Branch and Royal Adelaide Hospital.

MORE INFORMATION

National Pregnancy Care Guidelines
https://bit.ly/2FSiWME
SA Syphilis Register 1300 232 272 / Health.SASyphilisRegister@sa.gov.au
National STI Guidelines
https://bit.ly/2Tr8XWq
SA Health Guideline
https://bit.ly/2uRj4K3
Adelaide Sexual Health Centre
www.sahealth.sa.gov.au/adelaidesexualhealthcentre

Preventing avoidable infant deaths

Clear factors are now associated with a higher risk of SIDS, writes Wellbeing SA's Dr Emma Dawes.

Wellbeing SA Public Health Registrar Dr Emma Dawes

The SIDS story over the past 25 years is considered one of the great successes in infant health care. Since public health campaigns around safe sleep for infants in the mid-1990s, the incidence of sudden unexpected infant deaths in sleep has fallen by 85 per cent, and in Australia alone it is estimated that almost 10,000 lives have been saved. The development of safe sleep guidelines is an excellent example of how translation of evidence into public health policy can save lives, and a sobering reminder of the consequences when evidence is not effectively translated.

Sudden death in an otherwise healthy infant during sleep is not a phenomenon of modern times. Early examples of public health policy designed to curb deaths are known to have existed in the 7th century. The phenomenon, known as SIDS since 1969, has been understood to be a complex combination of intrinsic and environmental factors, rather than a single pathological process, since the mid-20th century. It was not until 2004, however, that an internationally accepted common definition for the term SIDS was agreed upon.

Despite being a phenomenon of interest from the early 1900s, the changing definition, absence of tissue-based pathological features, and the highly emotive environment in which deaths were investigated resulted in marked heterogeneity between studies and their findings. As new theories for its cause emerged, numerous and often contradictory recommendations for 'safe sleep' were advocated (with variable uptake), clouding the already complex landscape.

Thanks to epidemiological practices (making particular note of work done by South Australian researcher Susan Beal from 1970 to 1990), clear factors are now associated with an increased risk of SIDS. These factors have been incorporated into 'safe sleep' campaigns, such the 'Back-to-Sleep Campaign' since 1995, and the subsequent 85 per cent decrease in SIDS deaths is attributable to reductions in these risk factors.

The success of safe sleep campaigns is heralded as a public health triumph and has led to them becoming a 'poster child' for the benefits of evidence-based medicine. In many ways it is a triumph. A retrospective review of evidence, however, reveals that if a systematic

SUDDEN INFANT DEATH SYNDROME (SIDS)

The sudden unexpected death of an infant less than one year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.
(San Diego definition, 2004)

SUDDEN UNEXPLAINED DEATH IN INFANCY (SUDI)

The similar, and often confused, term is SUDI is an umbrella term for 'the sudden and unexpected deaths on infants under one year of age whose deaths remain unexplained at autopsy, including but not limited to SIDS deaths'. As well as deaths from SIDS, SUDI encompasses infants whose deaths occurred in the course of an acute illness that was not thought to be potentially life-threatening, arose from a pre-existing condition that had not previously been recognised, or resulted from any form of accident, trauma or poisoning.
(Blair, Byard, Fleming, 2009)

review had been performed at the time, there was sufficient evidence to change infant sleeping practice from as early as 1970. Instead, the failure to appreciate the strength of evidence, and modify practices accordingly, resulted in the continued promotion of front sleeping for another 30 years. The predicted 60,000 deaths that could have been prevented reminds us as clinicians of the importance of efficiently translating evidence into practice; failure to do so has had, and will continue to have, dire consequences.

Now, despite the success of public health campaigns and the dramatic decrease in prevalence, SIDS remains a leading cause of preventable death for infants between one and four months of age. Coroners' reports into infant deaths in Australia attributed to SIDS and SUDI over the past 10 years suggest that in many of these deaths there remain preventable elements: infants are often found to have one or more identifiable risk factors for sudden death, and/or to be sleeping in environments that do not meet all of the current safe sleep standards. While there is only a small number of unexplained sleep-related infant deaths in South Australia each year, these deaths have a devastating impact on those involved. And evidence suggests each one could have been prevented.

As medical practitioners, it is our role to reduce the risk of SIDS and SUDI through helping our patients understand the importance of care and sleep environments and practices that evidence has shown to be safe. We should offer culturally inclusive advice that nurtures and affirms parents and carers, empowering them to make safe choices.

SA SAFE INFANT SLEEPING STANDARDS

The SA Safe Infant Sleeping Standards were developed by government and non-government experts under the direction of the South Australian Safe Sleeping Advisory Committee in 2011. The guidelines were revised in 2016, and again in 2018, to reflect current best practice and legislation. They can be accessed on the SA Health website.

MODIFIABLE RISK FACTORS

- Infants in a prone (face down, tummy) sleeping position
- Unsafe cots, mattresses and bedding
- Parental smoking (before and after birth)
- Use of alcohol and other drugs, including prescription medication, that makes the parent/caregiver drowsy and less responsive to infant cues
- Infants and parents/caregivers sharing the same sleep surface (such as bed, couch, sofa, chair etc.).

PROTECTIVE FACTORS

- Sleeping an infant in the same room as the parents/caregiver
- Ensuring that an infant is fully immunised
- Using a pacifier (once breastfeeding has been established)
- Breastfeeding

INFANT-SPECIFIC FACTORS ASSOCIATED WITH INCREASED BASELINE RISK

- Infants born prematurely (<37 weeks)
- Infants of low birth weight (<2,500g)
- Multiple births
- Male and first born infants
- Infants who have problems after birth, including a history of minor viral respiratory infections and/or gastrointestinal illness

ENVIRONMENTAL FACTORS ASSOCIATED WITH INCREASED BASELINE RISK

- Young parental age
- Mental health problems or cognitive difficulties experienced by parents/caregivers
- Domestic violence occurring in households
- Transient lifestyle, with lack of access to a stable home.

Specific notes on safe cots, mattresses, and bedding: The Australian Standards for Household Cots (AS/NZS 2172) have been developed to guide parents and clinicians. Further, there is a voluntary AS/NZS safety standard for cot mattresses, including an assessment of their firmness to reduce the risk of SUDI and SIDS from soft mattresses. A flat sleeping surface is recommended at all times: There is no evidence or requirement to raise the head end of a cot to treat gastroesophageal reflux; this can instead result in babies slipping down under covers

Specific notes on sharing a sleep surface: Research suggests the risk of sharing a sleep surface can be compounded by modifiable risk factors, but removing these additional factors does not return the risk to baseline, and the practice remains higher risk than that of sleeping an infant on a separate, safe, sleeping surface.

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Massive shakeup for income protection insurance

A proposed overhaul of income protection insurance aims to stem the billions of dollars being lost by insurers each year and could have enormous implications for anyone considering a policy.

Ms Hannah Waller (left) and Mr Mark Mullins of Hood Sweeney

Some of the mooted changes could come into effect as soon as April 2020 and would affect all new income protection insurance contracts, and potentially any changes being made to existing contracts.

This type of insurance, also known as disability income insurance, can provide replacement income to policy holders if illness or injury render them unable to work.

'As it currently stands, it can protect a family financially in the event of debilitating injury or illness, providing a replacement income of up to 85 per cent and allowing time for recovery without the added stress of mounting bills,' said Mark Mullins, associate director and representative of Hood Sweeney Securities Pty Ltd.

Mr Mullins said one of the most radical proposals would restrict the benefit payment period to a maximum of five years – a major change from the existing benefit period up to age 65.

'After five years, where would an income come from for people still recovering from an injury or illness?' Mr Mullins points out. 'How would they pay a mortgage, school their children, or put food on the table?"

The Australian Government's statutory authority, the Australian Prudential Regulation Authority (APRA), set a deadline for life insurers to start steps that include formulating a strategy to address the issues identified by the review and reviewing income protection insurance's product design and pricing practices to enhance its sustainability.

Some of the potential changes are outlined in the table (below).

The review comes amid APRA's concerns about what it cites as 'lenient' income protection insurance sold to individuals. The industry has collectively lost more than $3 billion through this product offering over the past five years, with no signs of improvement.

APRA wrote to the industry in May 2019 requesting action to address the problems. Since then, insurers have reported further losses of $1 billion, prompting APRA to escalate its response.

With at least one major reinsurer indicating it was no longer prepared to reinsure individual income protection insurance, APRA Executive Board Member Geoff Summerhayes said there is now a genuine risk that insurers may start withdrawing from the market.

'Disability income insurance plays a vital role in providing replacement income to policyholders when they are unable to work due to illness or injury,' Mr Summerhayes said.

'In a drive for market share, life companies have been keeping premiums at unsustainably low levels, and designing policies with excessively generous features and terms that, in some cases, provide a financial disincentive for policyholders to return to work.

'Insurers know what the problems are, but the fear of first-mover disadvantage has proven to be an insurmountable barrier to them making the necessary changes. By these measures, APRA is forcing the industry to better manage the risks associated with disability income insurance and to address unsustainable product design features – or face additional financial penalties.'

If you are considering an income protection policy, or if your current policy needs a review, call Hood Sweeney on 1300 764 200 to explore options to suit your needs.

Current income protection contracts	Proposed income protection changes
Income based at time of application or time of claim	Income based at time of claim only
Benefit period to age 65	Benefit period restricted to five years
Up to 85% of income insured	Maximum 75% of income insured
Guaranteed renewable contract	Initial contract term not exceeding five years (with option to extend based on contract at the time of extension)

Mark Mullins is an Associate Director and Representative of Hood Sweeney Securities, AFS Licence No. 220897,

Hannah Waller is a Life Risk Specialist and Representative of Hood Sweeney Securities, AFS Licence No. 220897.

An international perspective

RAH intern Dr Anthony Leahy (left) with writer Dr Diana Hancock

Dr Diana Hancock has new views on paediatrics after an elective in Africa.

In August 2019, I travelled to Botswana to complete a medical elective in paediatrics. Botswana has a population of 2.3 million people, and has high levels of education with a high GDP per capita compared to neighbouring countries in southern Africa. However, there are many public health issues and a lack of medical services, particularly for patients who do not live in the capital city.

I spent six weeks doing my elective working with the doctors in the paediatric medical ward and the special care babies unit (SCBU) at Nyangabgwe, the second-largest national referral hospital in Botswana, in the eastern-border city of Francistown. The paediatric ward had 15 to 30 patients while the special care babies unit and neonatal intensive care had 40 babies.

In Botswana, there are low rates of contraception use and pregnancy planning, and therefore low uptake of folate during the first trimester. Neural tube defects such as myelomeningoceles are common. Most of the patients in the SCBU were premature or had neonatal sepsis or neonatal jaundice. Unfortunately, due to a lack of ultrasound during pregnancy, some of the patients in SCBU had congenital conditions like trisomy 18 and severe hydrocephalus that were not diagnosed until after delivery.

There were a few cases which particularly made me realise the importance of having good public services available. The CT was broken

The Nyangabwe Referral Hospital's paediatric medical ward (above) and Special Babies Unit (right).

when we were there, so for months any public patients were unable to be scanned despite presenting with acute cerebrovascular accidents. One patient (I'll call Kylie), was eight years old and had rheumatic heart disease. She received medical care at the hospital, but due to a lack of specialists had to be flown to South Africa for surgery. By the time this was organised, she had developed severe pulmonary hypertension. Her heart failure meant that her procedure had to be delayed by months, and she had to return to Nyangabgwe and wait. Many children with type one diabetes presented in diabetic ketoacidosis because they didn't have access to blood glucose strips at home.

The doctors demonstrated a great deal of resilience working in an understaffed hospital, often with insufficient

resources. They valued teaching, and grand rounds and intern presentations were scheduled weekly. Because of the frequency of presentations of conditions such as meningitis, they were very good procedurally. Another positive aspect was that the paediatric team was very kind and friendly, both to the staff members and to patients. One of the nurses often encouraged four of the long-term paediatric patients aged between eight and nine years, including Kylie, to sit at a desk on the ward and complete maths lessons.

Climate change has already affected semi-arid Botswana, where about 70 per cent of the land is within the Kalahari Desert. A decrease in rainfall has brought longer dry seasons to people living in rural areas. These people will be vulnerable to the effects of climate change that may further limit agricultural activities. Most fresh produce is imported from South Africa and already too expensive for most families. This is leading to oedematous malnutrition in many young children.

Electives for medical students are a fantastic opportunity for students to do placements that are in an area of interest, both medical and geographical, and experience a health care system outside of the hospital where they have trained. It is valuable to gain an understanding of working as a doctor overseas and seeing the scope of medicine and public health outside our own cities. For students travelling overseas, it is important to be confident and be able to work safely with adequate supervision, but also to be aware of their clinical limitations as a student.

Being an AMA Councillor in 2019 gave me the opportunity to see and be grateful for different elements of our healthcare system. I am so glad I've had the opportunity to travel overseas for my elective and hopefully can return when I have more training.

Dr Diana Hancock is an intern at the Queen Elizabeth Hospital and in 2019 was a student representative on the AMA(SA) Council.

Dr Diana Hancock (left) and Mount Gambier intern Dr Ilze Alexander.

Considering beliefs about stress, hardship and growth

It may be hard to believe, but stress can be good for us.

By Dr Troye Wallet

Belief is a weak word. It implies a degree of uncertainty and a choice rather than a truth. Climate change seems to be something about which some of us hold a belief, which can invite discussion and argument, whereas there is no choice when it comes to accepting the presence of gravity. When you trip there is no negotiation, there is just falling.

However, there is power in belief. It dictates and governs our reality. What we think influences directly who we are, what we are, and how we walk through the world. This concept may require some individual thought and convincing, but accepting it as true can save your life.

EXPLORING BELIEFS ABOUT STRESS

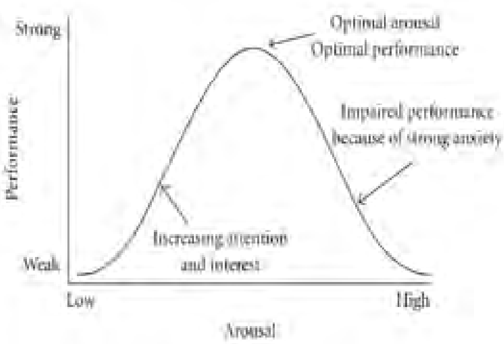
It is well known that stress is a risk factor for morbidity and mortality. Heart attack, abdominal symptoms and mental health deterioration are a few broad areas caused by a stressful life.

Stress increasing mortality, however, it is not entirely true. It turns out that a person's belief and the way they think about stress has considerable impact on the effect of stress.

In 1998, 30,000 people were asked about their stress and whether they thought their stress was affecting their health. Twelve years later, the results were both predictable and surprising. Predictably, the highest mortality was among those who had reported a high level of stress and reported it was affecting their health. The surprising finding was that the lowest mortality was among those who reported high levels of stress but believed that stress was beneficial to them.

It seems stress itself is not the problem, but rather the belief that stress is bad for one's health. By reframing and considering stress to boost productivity and vitality, the delirious effects diminish. The way one views the world directly changes their reality.

THE YERKES-DODSON STRESS PERFORMANCE CURVE



THE STRESS PERFORMANCE CURVE

Thinking about stress as a positive influence does not mean it does not deserve consideration as a negative influence. The stress/ performance curve shown above, first described by psychologists Robert M. Yerkes and John Dillingham Dodson in

1908, demonstrates how stress can be useful in managing a challenging job or situation. As one's stress increases, performance increases. Up to a point. After that, performance drops off. Understanding that each person's stress/performance curve is unique gives insights into how different people work. If you are managing a team or mentoring a junior or advising a colleague, ask them how stress affects their performance. Does their curve drop off quickly? If so, managing high levels of stress is vital for maximum performance. For others, stress is a motivating force and working under a high load or to tight deadlines is beneficial. As long as they think of stress as a positive part of their lives, they will thrive.

POST-TRAUMATIC GROWTH

It seems that belief is stronger than initially stated. If just the knowledge that stress is not unhealthy removes the risk it imposes, perhaps the same concept is true in other areas.

Tragedy, such as the loss of a loved one or caused by the bush fires in Australia, leads to suffering, grief and heartache. Events like these devastate people's worlds; terms such as post traumatic stress start to be mentioned to describe their responses. 'PTSD' – post-traumatic stress disorder – is now part of the public consciousness and, unfortunately, a common outcome of living through a life- or world-shattering event. The grief, loss and feelings felt in these times are raw and hard to deal with.

However, in that pain is the possibility of Post Traumatic Growth. Perhaps it is not discussed as much, because

... Post Traumatic Growth is more likely if people understand that it is a possibility ...

it is easy to come across as lacking empathy. However, being cognisant of Post Traumatic Growth may open the possibility of using pain to be stronger than before.

Post Traumatic Growth was theorised by Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s. The theory suggests that people who experience a psychological struggle can see positive personal and spiritual growth or a greater appreciation of life as a consequence of trauma. It is more commonly seen in people with a growth mindset and who seek out connection with others. Tedeschi and Calhoun suggest that Post Traumatic Growth is more likely if people understand that it is a possibility. A belief can change the outcome of how people deal with tragedy. If they believe it is possible, it becomes possible.

TWO BELIEFS THAT WILL SAVE LIVES.

When belief is explored, it is not unbelievable that it is more powerful than expected. The cliche that knowledge is power cannot be overstated.

Knowing and believing that stress improves your productivity and vitality makes it so. Realising that there is opportunity to grow and strengthen in the face of tragedy makes it a possibility.

Knowing and believing can save your life.

Dr Troye Wallett is an aged care GP, business mentor, writer and speaker.
troye@troyewallett.com

AMA(SA) remembers its first female president

Dr Jeanette Linn OAM

MD, FRACGP, SSStJ, CLJ.

AMA(SA) President 1980-81

7 September 1930 - 19 November 2019

'She used all her gifts to try and make the world a better place.'

Jeanette 'Jenny' Linn was a woman whose gravitas was unusual for women of her generation, which led to discomfort among colleagues and patients who perhaps weren't ready to confront and accept female medical practitioners.

She was born Jeanette Thrush Brentnall Gard, somewhat celebrated as the first girl to be born into her family for generations. Her parents Harold Gard and Vera Thrush were both professional opera singers and teachers, factors no doubt responsible for Dr Linn's lifelong love of music and education – passions she passed on to her children and grandchildren.

Despite the tough economic conditions, she was educated at St Peter's Girls School, which she said was instrumental in her development as a strong, determined, confident, faithful and compassionate woman. She graduated from St Peter's Girls at 16 and began medical school at the University of Adelaide in 1947, finding herself one of the few young women among a cohort largely comprising ex-World War II servicemen.

Among the former servicemen was John Linn, six years older than Jenny. She graduated in 1953 and married John Linn the same year. They set up a country practice in Mallala, beginning a professional partnership that lasted until John Linn died in 2000, and began raising four children: Bruce, twins Peter and Sally, and Jack. Sally died aged six in 1962.

It was many years later that her sons learned that there was significant community resistance to her being both doctor and mother in the regional town. 'Jenny's life would have been significant now but was truly outstanding for a woman born in the 1930s,' Bruce said.

The family moved from Mallala to suburban Walkerville in 1969, and over subsequent years Jenny welcomed daughters-in-law and, in 1977 and at the age of 46, the first of seven grandchildren. Her initial response was an indignant 'I'm much too young to be a grandparent,' Bruce said.

In the 1970s, while running a busy general practice and becoming the first medical superintendent of the Walkerville Nursing Home, she completed her MD, focusing on the role of the nurse in chronic illness care and treatment. 'She recognised the importance of interdisciplinary care several decades ahead of much of her profession,' said Jack.

At the same time, Jenny became increasingly involved in the politics of medicine, culminating in her being the first female president of the AMA in South Australia, and later sitting on the AMA's Federal Council.

She was awarded her fellowship of the of the Royal Australian College of General Practitioners in 1971, the only female GP to participate in and then pass the first Australian exam seminar. She served on and chaired several committees, including those focusing on family planning, publications and accreditation. She sat on the RACGP board for many years and was the first female provost of the South Australian and Northern Territory faculty.

Her work with young graduates extended to the University of Adelaide, where she was a member of Council, clinical senior lecturer in the Department of General Practice, convenor of the Academic Progress Appeals Tribunal, and held various roles with the Alumni Association.

She also found the time to contribute to the Medical Board of SA, the Administrative Appeals Tribunal, the Legal Practitioners Conduct Board, the St Andrews Hospital board, the sapmea board, and pursue a special interest through her membership of the Aviation Medical Society.

'Jenny had a strong sense of community, and much of her life energy, including her professional role, was directed toward church and community,' Jack said. 'Even after her retirement from general practice, she continued to be a community leader, including as an elected member of the Walkerville Council and a member of both the Order of St John and the Order of St Lazarus.'

Peter said that after the death of their father, her second husband John Hain gave her 'new energy and life'.

'John supported her as she declined as a result of dementia,' Peter said.

Jenny was recognised with a Medal of the Order of Australia in the 2002 Queen's Birthday Honours List, 'for her services to the medical profession as a general practitioner, lecturer and health advisor, particularly in the field of geriatrics, and to the community through a range of education, church and women's groups'.

Dr Jeanette Linn, second from left, is pictured with Dr Thea Limmer, Dr Janice Fletcher, and Dr Trevor Pickering at the unveiling of her portrait, which now hangs in AMA House.

'She was passionate about the health and education of young people, working at the Student Health Service at the University of Adelaide for many years,' Jack said. 'She was a mentor to a generation of young people, enabling them to achieve their potential.'

Among them was a young Dr Clare Fairweather, who managed Jenny's care in her final years.

Outside her professional roles, Jenny was involved with St Peter's Cathedral for many years, including as the first female Dean's Warden and later at St Andrew's Walkerville. She loved flowers, arranging flowers at the Cathedral for many years, and the Cathedral music.

'Our mother was a role model to a generation of young people, including at the professional, community and family levels,' Peter said. 'She used all her gifts to try and make the world a better place.'

From the eulogies read by sons Bruce, Peter and Jack Linn at Dr Linn's funeral

2020 GALA DINNER

Join friends, colleagues and the wider medical fraternity at the 2020 AMA(SA) Gala Dinner at the Adelaide Convention Centre on 23 May. Organise a table for what promises to be a fantastic evening of fun, colour and spectacular entertainment.

The 'Disco Lights' theme is a chance to dig out your John Travolta suits and Xanadu glitter or your black-tie attire.

For bookings or queries, please contact Rebecca Hayward on 8361 0108 or at membership@amasa.org.au

AMA(SA) ANNUAL GENERAL MEETING

The Annual General Meeting of the AMA(SA) will be held at AMA House at 8 pm on Thursday, on 7 May 2020.

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.

NOMINATIONS FOR AMA(SA) COUNCIL

AMA(SA) members are invited to consider nominating for AMA(SA) Council.

The Council welcomes nominations for the positions of President and Vice-President.

It also seeks eight 'ordinary members' and four regional representatives for two-year terms beginning at the same time.

If you are interested in nominating, request a nomination form from Claudia Baccanello by calling 8361 0109 or emailing claudia@amasa.org.au. For conditions and enquiries relating to the nominations, please contact the Chief Executive Officer, Dr Samantha Mead, on 8361 0109 or CEO@ amasa.org.au

Nominations close at COB on Wednesday, 25 March 2020.

Members are reminded that you are welcome to attend AMA(SA) Council meetings. Meetings are held eight times a year (there are no meetings in January, April, July and October). The next meeting is scheduled for Thursday, 5 March at 7 pm. Any member wishing to attend should contact Claudia Baccanello on claudia@amasa.org.au or 8361 0109.

AMA(SA) ANNUAL AWARDS

Each year, the AMA(SA) presents two awards at the Gala Dinner: the AMA(SA) Award for outstanding service in medicine and the AMA(SA) Medical Educator Award. If you wish to nominate a friend or colleague for the 2020 awards, which will be presented at the Gala Dinner on 23 May, please download the nomination forms on the AMA(SA) website or contact Claudia Baccanello at claudia@amasa.org.au. Nominations must be received by COB on Friday, 27 March 2020.

HELPFUL HINTS – LOGGING INTO THE MEMBER PORTAL

Are you having trouble logging on to update your details, renew your tax-deductible membership for 2020, or print your tax invoice? Here's a simple tip to help:
Head to: members.amasa.org.au
Username: your email address
Password: whatever you have set this as.

IS YOUR DATA CORRECT?

Early career doctors are encouraged to review their membership accounts to ensure the AMA(SA) database has accurate details.
For example, some interns forget to provide new email addresses to replace their student contacts. If you're currently registered as a student member and you're now an intern, please let us know and we'll change your membership category.
To check your details, log into your account or contact membership@amasa.org.au.

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Phone 1300 764 200 or email amasa@hoodsweeney.com.au with your query or to contact one of their medical-profession specialists.

Hood Sweeney also holds regular seminars at AMA House, which are free for members to attend. For details about forthcoming events, including 'Life Begins at Retirement' on 11 March, please visit www.amasa.org.au.

SUPPORTING PROFESSIONAL DEVELOPMENT

Created by the Australian Medical Association, doctorportal Learning works with the best subject-matter experts to help doctors access and complete their development obligations.

The educational content goes beyond clinical topics to include aspects such as difficult conversations, ethics and professionalism, and leadership.

For more information go to www dplearning.com.au

The AMA also has a range of practice support tools for members, such as the GP Practice Support Toolkit. For more information about resources about a range of specialty and professional development topics, visit www ama com.au.

If you're a doctor in training, you may want to ensure you've covered all the bases when applying for positions. The career resources at ama.com.au/careers/career-coaching are designed to help you understand what you're applying for, and how to stand out from the crowd.

PLANNING FOR THE YEAR AHEAD

The AMA(SA) office has a limited number of 2020 wall planners to give away. If you'd like one, please email membership@amasa.org.au – first in, first served!

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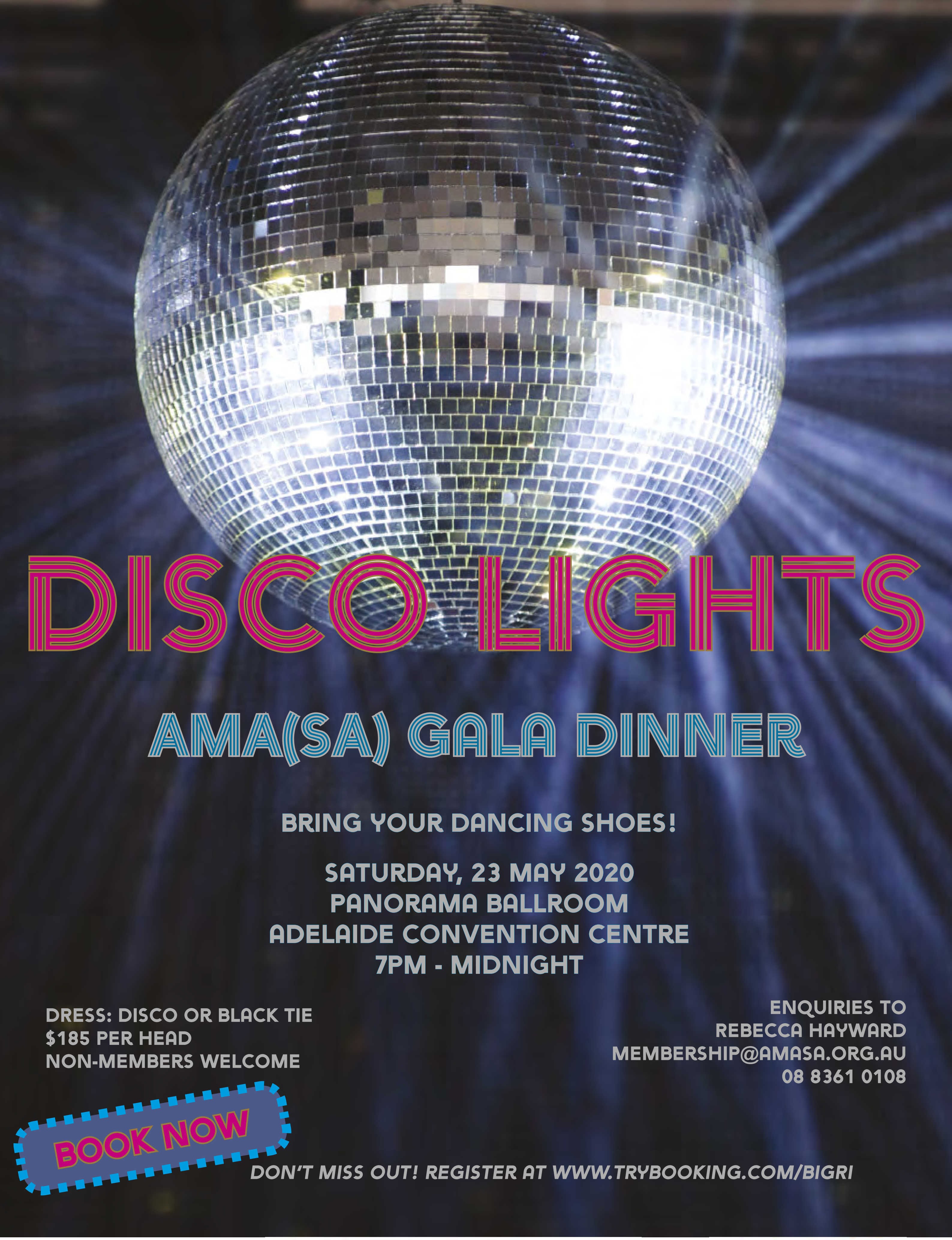
AMA(SA) Doctors Group & AMA(SA) Doctors in Training Committee

Please add #amasamember to your pictures so we can see them and share!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