medicSA
JUNE 2020 VOLUME 33 NUMBER 3

The new normal

Practising medicine during and after the pandemic

AMA SOUTH AUSTRALIA

POST-OP COMPLICATIONS – THE HIDDEN PANDEMIC • VALE SENIOR MEMBERS • POLIO'S PERMANENT REMINDERS • THE DEANS' LISTS

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MEDICAL IMAGING

Dr Jones & Partners is pleased to introduce

Dr Malalagama, Dr Paterson and Dr Moon

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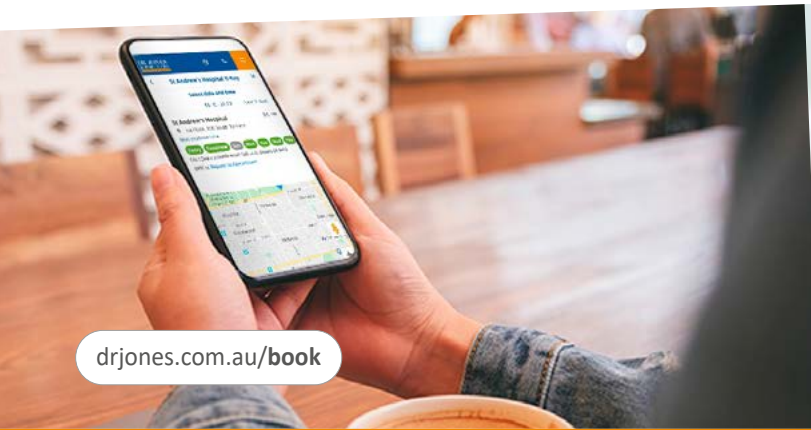
Dr Geethal Malalagama and Dr Helen Moon join our experienced team of radiologists. Dr Malalagama has a keen interest in Neuroradiology, Abdominal imaging and more broadly in CT and MR imaging. Dr Malalagama also holds a position at the Flinders Medical Centre.

Dr Helen Moon has a special interest in trauma imaging and delivering medical student education. Dr Moon additionally holds a position at the Royal Adelaide Hospital.

We also warmly welcome back Dr Felix Paterson, who has recently returned from Hobart after completing his second year of Nuclear Medicine training with Calvary Lenah Valley (I-MED) and the Royal Hobart Hospital. Dr Paterson will work across both radiology and nuclear medicine, with a special interest in Oncology, PET, Nuclear Medicine and Neurology.

We are delighted to have Dr Malalagama, Dr Moon and Dr Paterson join our specialist doctor team.



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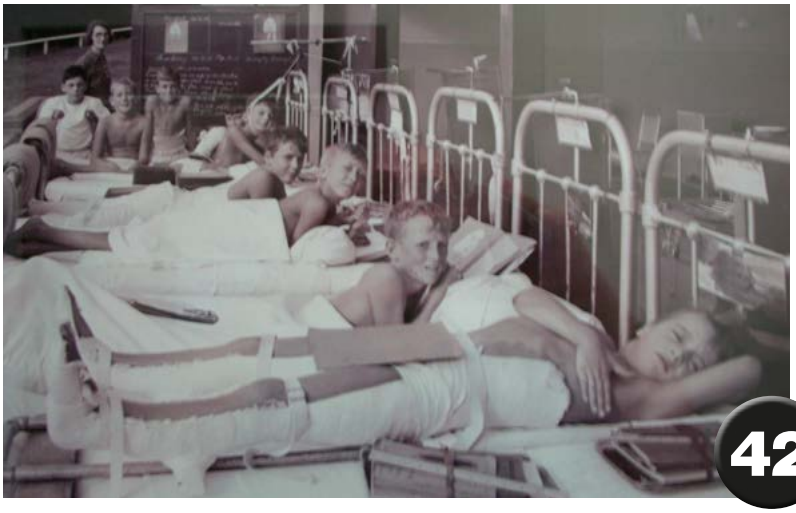

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What will COVID-19 bring?

These Victorian boys of the 1930s suffered from one of the worst diseases to afflict Australian children: polio. Decades after they survived the pandemic itself, they would be forced to bear other symptoms related to polio, including worsening fatigue and new pain, that no one expected – and that today's doctors are still learning to recognise and diagnose.

Dr Divya Sabharwal
General practitioner
South Australia

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President's report

Dr Chris Moy

Not remotely normal

One evening during the height of the physical distancing restrictions, my wife and I received a text query from our daughter, Natasha, who was alone in her bedroom from which happy music was thumping and computer-generated flashes were seen emanating from the gap under her closed door. When my wife Monika decided to respond with a vocal answer, she was met with two happy but abrupt text communications from my daughter: 'I'm busy' followed by 'I'm at a party'.

It's been a strange and intense five months for us all. I guess a pandemic will do that.

While we doctors have experienced varying degrees of anxiety and exhaustion in facing both the health threat of COVID-19 on our patients and ourselves, and the impacts on our businesses, there has been an inspiring spirit of community permeating our profession. In a column published in the *Sunday Mail* in late March, I asked South Australians to be kind, generous and big-hearted. I have to say that with few exceptions, the people of this state have come through. In giving evidence to Legislative Council COVID-19 Response Committee in late May, I reported that if South Australia was a footy team, the newspaper report could have summarised performances in the early stages of this critical game as 'all played well'.

We as the medical profession – for which the AMA is the only voluntary organisation representing *all* doctors – should feel a significant level of pride in our parts in the effort. And as I write this in mid-June, South Australia is one of the safest places in the world to be.

Yet still we function within what is being termed 'the new normal'. Handshakes and hugs have been removed from our social encounters and may never return. A return to emphasising hand washing, harking back to the times of polio, is an irony in our supposedly first world society. And physical distancing is leading to the twin effects of reduced social connectedness and mental health stresses, compounded by unheard-of economic challenges.

Doctors are not only at the front line of caring for patients in this new society; we are struggling with the changes, too. With this is mind, #CrazySocks4Docs came as a timely reminder that we doctors are human and that we must consider both our own mental health needs and those of our colleagues. Only then can we genuinely heal our patients.

Much like my daughter's attitude towards her virtual party, one factor that has created an unexpected positive psychological element during this time has been the 'can do' approach that has dominated over the naysayers. Contrast this with the pervasive air of negativity, cynicism and pettiness that can be found when some decision-makers or community members find reasons not to change things for the better.

With this in mind, I point to the article on page 10 regarding the need to reduce the genuinely extraordinary and appalling number of patients who suffer and die from post-operative complications. This is the third most frequent cause of death worldwide, with 4.2 million people dying within the first 30 days of surgery each year. Australia does no better; in addition to reducing harm to our patients, it is estimated that even a 15 per cent reduction in post-operative complications would lower costs by $1.2 billion a year – a relevant statistic in our debt-affected post-COVID world. Implementing changes to reduce these complications seems to be not a 'can do' but a 'must do'.

Led by organisations such as the AMA, doctors around the world have made such a difference in confronting the virus so far. I hope that, for the sake of our patients, we can continue this spirit so that health in South Australia continues to adapt and 'do'. And, as a result, we can extend this current mood of each of us playing our part into the quiet satisfaction found in careers of contribution and service.

… one factor that has created an unexpected positive psychological element during this time has been the 'can do' approach that has dominated over the naysayers …

Editor's letter

Dr Philip Harding

Most South Australians will remember the name of Edward Gibbon Wakefield because of his role in setting up the South Australian colony in the early 19th century. Those who don't know that will have noticed there are many places in the state named after him, including a port, a river, numerous roads and streets (including the one in which I live) and most recently a hospital. However, Wakefield Hospital has recently forsaken that name, having moved to new premises at Calvary Adelaide.

Last year while on holiday in Christchurch, New Zealand, my wife and I were intrigued to discover Wakefield's name to be well-known, a legacy of his role in the settlement of the surrounding Canterbury area in the 1840s. When we travelled on to the North Island, further evidence emerged of his involvement, along with other members of his family, in the establishment of Wellington. Wakefield's interests in colonisation, developed during a period of imprisonment for abducting an heiress with a view to marrying her, extended well beyond Australasia to involve Canada and other parts of what was then still the British Empire. Another interesting link was that George Grey, the fourth Governor of South Australia, had also twice been appointed Governor of New Zealand, a role in which he had a long-running conflict with Wakefield who by then had assumed high political office in that country. Edward Gibbon, whose difficult and chequered life is itself a very interesting story, spent his last years in New Zealand but never visited South Australia.

Then, while at an international conference earlier this year (when such things were possible!) I mentioned some of this story to a New Zealand colleague, who told me that the two largest private hospitals in Wellington are Calvary and Wakefield, the latter indeed named after the said Edward Gibbon. The connections continue – and if, as has been suggested, Australia and New Zealand form a 'travel bubble' in emerging from the pandemic, this may be a subject worth exploring on the other side of the pond.

New board member for AMA(SA)

Strategy and governance expert Megan Webster has joined the Executive Board of the AMA(SA).

Ms Webster has more than 15 years of experience as a senior executive in the South Australian Government. Her background also includes law, human resource management, social policy (health, higher education and employment), government relations, strategic communication and governance.

Ms Webster has been an advisor to premiers, and as the first Executive Director of Leadership and Governance for the South Australian Public Sector led sector-wide employment, leadership development, induction and culture change programs.

More recently, she led extensive changes in the South Australian Courts, including the introduction of a new electronic courts management system.

In 2015, Ms Webster has served as Chair and Deputy Chair of the Board of Regional Development Association (RDA) Adelaide. Other appointments include roles with the University of Adelaide Alumni Council, University of Adelaide Council Selection Committee, Cure for Cystic Fibrosis Foundation, and the State Records Council.

'This has been a year like no other, and its challenges have tested organisational responsiveness and agility as we've not seen before,' Ms Webster said.

'I hope to contribute significantly to the good governance of the AMA, so the AMA(SA) Council can focus its attention on important matters of policy.

Dr Nelson welcomed Ms Webster to the Board.

'In what have been an extraordinary few months, our Board has worked hard to support and provide a platform for the Council, our members and AMA(SA) staff to perform their essential services,'

'Megan's experience expands the capacity of our group to address the range of important and in some cases unparalleled issues on our agenda in 2020 and beyond,' Dr Nelson said.

Ms Webster joins radiologist Dr Nelson, accountant Andy Brown, anaesthetist Dr Guy Christie-Taylor, along with Councillors Dr Chris Moy (President), Dr Michelle Atchison (Vice-President) and Dr William Tam (Immediate Past President), on the Board.

Above: AMA(SA) President Dr Chris Moy and fulltime and part-time office and Skills Training staff at the temporary Dulwich premises.

Left: The fire at AMA House caused an estimated $5 million damage.

New home for AMA(SA)

AMA(SA) staff have begun working in temporary premises at Dulwich following the fire that caused extensive damage to AMA House in May.

The fire, which was believed to have been deliberately lit, caused about $5 million damage to the building. Significant structural damage has required the AMA(SA) to vacate the offices for at least nine months.

AMA(SA) CEO Dr Samantha Mead said staff began working in the offices on Level 1 at 175 Fullarton Road on 22 June, after having worked from their homes since 26 March.

Dr Mead said it was a 'fortuitous by-product' of having staff work from home that the fire caused minimal disruption to AMA(SA) operations.

'Staff had transferred their computers and other equipment to their homes weeks before the fire, and were set up at home and accustomed to working outside the North Adelaide office,' Dr Mead said.

'We have visited the office to work with assessors and to mark what needed to be cleaned as a priority, so we have everything we need at Dulwich,' she said. 'It was distressing and disappointing to see the waste and realise the impact the fire will have on the businesses that leased other suites in AMA House.'

Dr Mead thanked Adelaide dentist Dr Bill Verco, who offered the Dulwich offices quickly and on helpful terms to support AMA(SA) and his medical colleagues.

AMA(SA) President Dr Chris Moy said the fire would not influence the AMA(SA)'s essential work during the pandemic.

'Our thoughts are with the medical practitioners and others who lease these suites,' Dr Moy said. 'We understand that the fire will have a distressing impact on their capacity to help their patients in what are already extremely challenging times for everyone.

'From an AMA(SA) perspective, we are extremely relieved that the fire has not caused any injuries. Property can be repaired. Buildings and premises can be rebuilt. But if there is anything that this pandemic has demonstrated, it is that people and their health and wellbeing must and do come first.

'The AMA(SA) is determined that our work in serving patients, members, health practitioners, the government and communities across South Australia throughout the pandemic will continue.'

AMA(SA) staff will be based at Level 1, 175 Fullarton Road, Dulwich, until further notice. All phone and fax numbers, email addresses and the PO address remain the same.

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A/Prof William Tam (State Nominee)
Dr Chris Moy (Area Nominee SA/NT)
Dr Matthew McConnell (Specialty Group Nominee: Physicians)

Lung cancer services expand in Elizabeth

Stereotactic Body Radiation Therapy (SBRT)

Now available

SBRT is an advanced, high precision radiation therapy technique that delivers ablative radiation doses while minimising dose to normal tissues.

For suitable patients, SBRT offers the following advantages:

Improved oncological outcomes with:

- Superior local control in early stage NSCLC due to higher (ablative) radiation dose compared with conventional radiation[1]
- Comparable survival to surgery for early stage NSCLC and oligometastatic disease[2,3]

Greater patient convenience with:

- Reduced radiation dose to surrounding healthy tissues resulting in less side-effects
- Fewer treatment sessions - usually 4 - 8 attendances compared to 20 – 33 with conventional treatment
- Faster treatment delivery times during each treatment session (20 minutes)

Patients potentially suitable for lung SBRT include:

Pathologically confirmed primary NSCLC or lung metastasis that is:

- Medically inoperable or
- Patient has declined surgery

High radiological probability of malignancy where pathological confirmation is:

- Technically not feasible/contraindicated or
- Declined by patient
- Stage T1/T2 (<5cm) and N0
- ≤ 3 synchronous metastases or oligoprogressive disease

Refs: 1. Ball D et al. Lancet Oncol 2019; 20: 494-503 2. Chang JY et al. Lancet Oncol 2015; 16:630-637 3. Ball S et al. The Oncologist 2016;21:393-398

Our radiation oncologists

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MBBS, FRANZCR

Dr Marcus Dreosti
BSc, Hons LLB, MBBS (Hons), FRANZCR

Dr Phuong Tran
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Dr Laurence Kim
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GenesisCare

Personal protection

An innovative AMA(SA) contract with a local medical device supplier is helping members access high-quality, locally made PPE in the pandemic.

The AMA(SA) has entered an agreement with leading Adelaide-based medical device manufacturer Austofix to support the local supply of TGA-approved masks for South Australian doctors and health workers.

Austofix designs, manufactures and distributes world-class orthopaedic devices.

Now, in response to the COVID-19 pandemic, Austofix has turned its attention to supplying masks tested in its purpose-built, TGA-approved device cleanroom technology and packaging facilities at Thebarton.

AMA(SA) CEO Dr Samantha Mead said the dire threat posed by the pandemic required the AMA(SA) to explore innovative ideas and extraordinary measures to support members.

'Austofix has presented us with an opportunity to help our members access the PPE they so desperately need while supporting a local company with a proven medical pedigree,' Dr Mead said.

'Across Australia and the world, doctors and healthcare workers have been forced to do their work without reliable PPE. Others have lost income as they stood aside to allow colleagues in ICUs and elsewhere to have masks and other equipment.

'This agreement helps us help our members when they need it most'.

Austofix CEO Chris Henry said his company had expanded into supplying PPE in response to the nation's most threatening health crisis in recent times.

Mr Henry said that as a manufacturer of orthopaedic implants for more than 25 years - and with its own state of the art clean room at Thebarton – Austofix was able to respond quickly and manufacture PPE when COVID-19 hit.

After receiving TGA approval to manufacture PPE on 23 March 2020, Austofix immediately secured components through its existing international network of medical suppliers. It shipped its first 'Austosafe' masks to hospitals in South Australia and Victoria in early May, becoming one of the first local manufacturers to produce and supply PPE to rigorous ISO 13485 quality standards.

AMA(SA) CEO Dr Samantha Mead and Austofix general manager Chris Henry with Austosafe surgical masks.

The high-level compliance makes Austofix one of only a handful of Australian suppliers able to offer sterile and non-sterile PPE.

'The clean-room facilities at Thebarton are certified to process Class 3 implantable devices, so diversifying to manufacture PPE was relatively straightforward,' Mr Henry said. 'We're keen to continue to invest in new manufacturing facilities here in Adelaide to expand medical device manufacturing.'

Dr Mead said it was important that members, hospitals and health services could access quality products in times of dire need.

'We are relieved and delighted to partner with a South Australian company like Austofix, which can work closely with our members to meet their specialised needs and create a secure long-term supply option right here in SA,' Dr Mead said.

'Austofix is a local company with credentials in the medical sector that is looking to contribute to better, safer working environments for doctors and other health practitioners.'

Mr Henry said Austofix would pursue international markets, particularly in the Middle East and Asia, when local demands are met.

The hidden pandemic

Urgent attention to the many unseen costs of post-surgery complications will be even more vital in a post-COVID health system, writes Professor Guy Ludbrook.

Surgery is an essential component of healthcare. It is necessary for a third of our disease burden, reflected in 2.5 million surgical procedures annually, and will be required to expand substantially in future years to maintain the health of Australians.

Access to safe and effective care for patients undergoing these procedures, however, is unlikely to continue without rapid action. We know already that postoperative complications are common, and that mortality after surgery is the third leading cause of death worldwide. Further, without attention, this problem will worsen, by up to 10 per cent annually by 2047, as Australia's population ages and co-morbid disease increases. These figures are mirrored internationally, making this a real – but very much hidden – pandemic.

NATIONAL SUMMIT

The impact on patients' health and wellbeing, and the cost to health services, means that continuing to turn a blind eye to this situation is no longer an option. This was confirmed at a National Summit in March this year, opened by Federal Health Minister Greg Hunt and his South Australian counterpart Stephen Wade, when 85 experts from around Australia, NZ, the UK and the US met in Adelaide. Their roadmap for the future, *The Hidden Pandemic of Post-Operative Complications - Meeting Report*, highlights how systems changes are essential, provides principles to underpin future activity, and provides 34 recommendations on actions to provide high-value care. Further, it provides a ruler against which to judge current and future care.

Since March, of course, we have experienced the COVID pandemic, with its tragic consequences on people's health and livelihoods, and on the economy. This suddenly jeopardises access to safe effective surgery and perioperative care even further. The Summit recommendations have become even more relevant and must be implemented to enact change.

SYSTEMS IMPROVEMENT

Systems thinking – understanding the important elements and how they best work together – was a key focus of the Summit. In healthcare – as explained by Louise Locock in 2003 – systems thinking means 'thinking through from scratch the best process to achieve speedy and effective care from a patient perspective, identifying where delays, unnecessary steps or potential for error are built into the process, and then redesigning the process to remove them and dramatically improve the quality of care'.

Designing an end-to-end, high-quality system based on relevant evidence has been commonplace in non-healthcare industries for decades.

WHAT DOES INDUSTRY DO?

McDonald's founders Richard and Maurice McDonald understood 70 years ago the importance of high-quality end-to-end food service – including personnel, space, machinery and workflow – without weak links. Interestingly, their approach of minimising unnecessary variation aligns with the views on quality of the Australian Commission for Safety and Quality in Health Care. Similarly, the movie *Moneyball* showed how the Oakland A's baseball team, faced with large budget challenges, introduced a 'Sabermetrics' systems approach and applied economic principles to baseball and was rapidly successful. Ensuring all elements (players) were good at the individual important activities (such as reaching first base rather than hitting the occasional home run) combined to produce the desired outcome (winning) and quickly led to high-value outcomes (victories cheaper than those more established teams could manage). Importantly, industry shows us that even large, established organisations such as Nestlé can rapidly reform their business: the Nespresso transition from instant coffee was achieved rapidly through small-scale demonstration, led by teams with change-management skills, then followed by widespread adoption.

Professor Guy Ludbrook addresses the National Summit

Medical journalist Dr Norman Swan mediating a Summit panel including (from left) Professor Ludbrook, British anaesthetist Professor Michael Mythen and Professor Katina D'Onise, Wellbeing SA's Executive Director, Prevention and Population Health

HEALTHCARE INDUSTRY

These analogies have direct and immediate relevance to surgery and perioperative care.

Firstly, we know the impact of end-to-end system improvement.

In medicine we frequently focus on individual, logically impactful surgical or perioperative elements such as medical devices (for example, robots) or new medicines (such as analgesics). We

often struggle to prove large benefit, especially across centres, in part because individual excellence can be undone by any weak link. There is also the issue of siloed thinking, in part as result of our disjointed healthcare structures and funding, such as for general practice, private specialist and public hospitals. Stakeholders are insulated from each other and, not surprisingly, frequently fail to effectively understand or engage with each other.

There is, however, observational evidence that end-to-end systems thinking is effective in surgery and perioperative care. The large National Emergency Laparotomy Audit (NELA) in the UK struggled to demonstrate the impact of individual high-quality elements (such as ICUs and consultants in theatre). However, the few centres with a geriatric service demonstrated a three-fold reduction in mortality. Undoubtedly geriatrics is essential for high-quality perioperative care of people in the relevant age group. However, in my view, it is more likely that this phenomenon reflected centres with the resources and foresight to develop high-quality end-to-end systems, magnifying the benefit of individual high-quality elements.

Secondly, we must understand what activities are important. The Summit report highlights the following as being beneficial:

- Genuinely understanding the consumer's wishes and expectations, so the selected care is likely to achieve their desired outcome
- Early consistent and formal risk and needs assessment – there is increasing evidence of the benefits of elements such as lifestyle change (such as exercise and smoking) and optimisation of comorbidities, but good lead times are needed
- Mechanisms to enhance decentralised care through community and primary care settings
- The pathways start with primary care
- Pathways and models of care must be explicit, match patient needs, and be based on evidence – pathways[2], and evidence for specific activities (in context), are now frequently adequately developed for jurisdictions to adopt
- Visibility of decisions, goals and plans, as well as progression through the pathway, must be recorded and available to all stakeholders.

Lastly, we need to understand the measures of success, which will include:

- Consumer feedback and experiences (measured against consumers' preoperative understanding of the risks and benefits of proposed surgery against their own goals)
- Relevant endpoints, built into standards
- High-value (outcome and cost) measures, accompanying all activities, initiatives and improvements in the system.

In Australia alone, it is estimated that even a 15 per cent reduction in postoperative complications will reduce costs by $1.2 billion a year. I suspect this is a modest target. Advanced recovery work at Royal Adelaide Hospital, in effect a new end-to-end model, showed closer to an 80 per cent reduction in key complications and re-admissions, and costs, suggesting rapid impactful change is feasible.

EXCELLENCE IS FEASIBLE, NOW

It has taken the recent COVID crisis to show us that rapid change in healthcare is possible. Remote access to patients; the rapid implementation of change using teams skilled at, and designed for, innovation; and application of high-acuity care in non-traditional settings with rapid staff upskilling; are simple examples. Going back from what has worked recently, to the previous pattern of stagnation and resistance to change, would be a lost opportunity. The large established business of surgery and perioperative care faces a sudden challenge of cost and quality post-COVID, but has the opportunity to improve rapidly because:

- The roadmap on priorities and activities exists[1]
- The end-to-end pathway exists, developed by the collective professional Colleges[2]
- Individual elements of excellence are proven (cost and quality), and readily implementable – for example, remote preoperative care[3] and advanced recovery[3]
- Evidence exists for key quality endpoints: readmissions or days-at-home[4] are reliable, available indicators of the quality of in-hospital care
- Electronic tools such as EMRs, and My Health Record will assist data collection and analysis
- Validated electronic tools exist for risk and comorbidity assessment – e.g. NSQIP[5]
- Primary care groups are already discussing elements such as early risk and comorbidity assessment
- Commissions now exist to assist jurisdictions with starting innovation and demonstrating excellence
- Partnerships with key organisations, such as University College London, bring expertise in large data management and modelling, risk assessment, A.I. and economics.

We can and must urgently implement excellence through a new system of perioperative care. The impact can be measured frequently and carefully. Subsequent iterations and new elements, such as enhanced primary care, can be added and their impact measured.

A hospital partnering with one or two others as Centres of Excellence can demonstrate small-scale high value and allow adoption over time, an approach fundamental to implementation science. Use of clinical trials tools and standards will ensure validity of the findings.

A table of very senior healthcare personnel at the Summit stated explicitly that someone should grab the opportunity 'by the b..ls', no doubt paraphrasing another successful business enterprise's catchphrase – 'Just Do It' (carefully).

If we don't, now, who will? This is a true pandemic – are we prepared to continue to live with the consequences?

The Summit's roadmap for the future has been released and is available at **https://thehiddenpandemic.com**

Dr Guy Ludbrook is Professor of Anaesthesia at Royal Adelaide Hospital, Head of Acute Care Medicine at the University of Adelaide and a practising anaesthetist in the public and private sectors, with postgraduate education in both business and economics. He will discuss the Hidden Pandemic report, and Advanced Recovery, in a (remotely delivered) keynote address at the Evidence-Based Perioperative Medicine (EBPOM) meeting in London on 02 July 2020.

1. https://thehiddenpandemic.com
2. http://www.anzca.edu.au/about-anzca/perioperative-medicine
3. https://bmcanesthesiol.biomedcentral.com/articles/10.1186/s12871-015-0057; https://topmedtalk.libsyn.com/topmedtalk-silent-pandemic-of-surgical-complications
4. https://bmjopen.bmj.com/content/7/8/e015828
5. https://riskcalculator.facs.org/RiskCalculator/

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Mid-game review: 'all played well'

AMA(SA) President Dr Chris Moy's statement to the South Australian Legislative Council COVID-19 Response Committee on 21 May 2020 provided a careful but optimistic view of South Australia's reaction to the coronavirus pandemic.

Dr Chris Moy during one of many media interviews during the pandemic

'I would firstly like to ask that all of my statements today are viewed through the lens of an appropriately wary doctor who does not feel that we can 'count our chickens before they hatch' in the face of an infectious threat that still poses so many uncertainties, and which we have been fighting for only a few months, with the likelihood of this continuing for some time to come.

However, I believe that South Australia has placed itself in the best position possible, even when compared with other states, and certainly when compared to other parts of the world, to have the greatest control of its destiny in re-emerging from a required constriction of society, while ensuring the greatest chance of the protection of the health of the community.

Again, without counting our chickens, I can tell you that the way that the pandemic has been handled in South Australia, and our position on such things as the reopening of elective surgery, have been discussed with some envy in other states.

I believe that this has occurred due to several very much interdependent factors here:

- recognition that decisions must be based on science and evidence
- a follow-on understanding that you must give health experts the room to make the right decisions
- a willingness of groups at all levels to work together and, instead of bickering, just get on with the job for the sake of the community …
- which, in turn, has allowed calm, clear, consistent communication to the community so that trust has developed …
- to which the public has responded well in a willingness to accept restrictions and the principles of physical distancing, which have been so critical in reducing the spread of COVID-19.

My first practical involvement regarding COVID-19 was when I contacted Chief Public Health Officer Professor Nicola Spurrier on Monday, 27 January 2020, following calls from GPs concerned about lack of PPE to be able to carry out tests for 'coronavirus'. I proposed an idea of my father: to have a stand-alone testing unit such as the one in Westmead, Sydney.

I also suggested a need for resources to support General Practitioners, which were beyond and at odds with what I felt were inadequate and problematic Commonwealth resources at that time.

…what has become obvious is that dealing with a pandemic is not a theoretical exercise …

An SA Health information session for GPs supported by AMA(SA) was held on 30 January and attended by Professor Spurrier, the Director of the Communicable Disease Control Branch, Dr Louise Flood, and the Clinical Service Director SA Pathology, Dr Tom Dodd. Despite a very tense meeting where quite a few frustrations were voiced, particularly by GPs of Chinese extraction who had been managing so well the first group at high risk of bringing coronavirus to SA: individuals who had travelled to or returned from China.

Professor Spurrier (and SA Health) took this on the chin and, instead of dismissing concerns and reverting to siloed thinking, chose to take all concerns seriously and work in a genuinely collaborative way with all front–line stakeholders providing health services.

This principle, I believe, became critical – because what has become obvious is that dealing with a pandemic is not a theoretical exercise, it is a practical one which must consider the practical issues of the front line.

By listening and working well together with other groups, and with the support of and input from AMA(SA):

- SA Health worked well to support the close-knit Chinese community and the community of doctors in South Australia, which mobilised early to implement measures such as self-isolation *before* national advice to do so
- SA Health developed specific signs for practices and clinics which were clearly superior to those in other states
- SA Pathology developed an information sheet on how to take a swab for coronavirus
- On my urging, SA Health developed an all-in-one flowchart for the frontline management of suspected coronavirus cases, which other states later requested
- SA Heath created an important position of GP Liaison (Dr Danny Byrne and Dr Emily Kirkpatrick) which has acted as the bridge between SA Health and frontline GPs
- from the GP Liaison office have come daily update and information emails for GPs
- GP Webinars have been staged to ensure GPs have the latest information and can ask the questions and address the issues that for a while were changing every day.

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Pandemic practising

As 'first responders' during the pandemic, GPs have agilely introduced dramatic changes to their usual systems, writes Dr Bridget Sawyer.

Dr Bridget Sawyer

Every GP in South Auftralia had to rapidly adapt to the changef COVID-19 imposed on the way we consult, prescribe, provide home visits and care to aged-care facilities. No one would describe it as an easy experience. Notwithstanding the difficulties, our state public health response has been acknowledged country-wide as being of high quality, well-coordinated and effectively led thanks to our state AMA President Dr Chris Moy, SA Health's director Dr Tom Dodd and Chief Public Health Officer Professor Nicola Spurrier.

Keeping abreast of the constantly changing public health advice has been demanding but important because of the imperative of providing the most up-to-date advice to patients who looked to us as a reliable source of information and support. The consistent and informative daily emails provided by SA Health and the GP liaison team, together with the weekly webinars hosted by AMA(SA), Royal Australian College of General Practice (RACGP) and Adelaide Public Health Network, have been a very valuable resource. I would like to take this opportunity to thank those involved in providing those emails and webinars.

Further, the introduction of telehealth item numbers was an enormous contribution, allowing GPs to provide the required care to our patients in addition to the financial support allowing us to keep our practices running.

I found telehealth care to be a valuable adjunct to routine face-to-face consulting. The benefit of assessment via a video consult far outweighed that of a phone consult; it is so much more valuable to see both your patient and their surroundings.

Our GP practice maintained both routine consultations and video/phone consultations throughout the period of lockdown. Those patients seeking face-to-face consultations waited in their cars and were screened via phone call before a decision being made as to whether it was appropriate to enter the building. This was not perfect, despite best efforts, but overall it worked well. Most patients welcomed the opportunity to be in contact with their trusted GPs and were very grateful for ongoing care.

I hope that telehealth, in some format, will be available through Medicare in the future to complement the hands-on care that we provide. I have been disappointed that some have seen telehealth as a business opportunity as opposed to a means to ensure the ongoing wellbeing of the vulnerable, chronically ill, house-bound or disadvantaged. It's not care to be provided by any provider at the patient's convenience, but it does need to be seen to be part of the provision of holistic GP care.

While there have been difficulties in the last few months there have also been advantages. I have welcomed the ease with which my specialist colleagues have assisted in my patient care with phone discussions, and reviews of imaging, ECGs or pathology reports. Online learning has been quickly embraced to speed us towards the necessary Quality Assuring Continuing Professional Development (QACPD) points.

The COVID-19 pandemic has required us to review the way we practise. These changes are here to stay and this may be more valuable in the long term than we think. If, overall, we are all more respectful of each other in the future, in which ever medical discipline we work, that will be a positive and important result.

Dr Bridget Sawyer is chair of the AMA(SA) Committee of General Practice.

Mid-game review ...

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These are a collaboration of SA Health, AMA(SA), RACGP and Adelaide PHN and are attended by up to 700s GPs and practices which have been key in supporting GPs across the state in responding to COVID-19.

The good working relationships have extended to the SA Health CEO Chris McGowan, the Minister for Health Stephen Wade, the Premier Steven Marshall, and also the Shadow Minister for Health Chris Picton.

Constructive effective dialogues behind the scenes have led to calmness despite some of the most massive disruptions and realignments in the health system occurring with urgency – the public takeover of private hospitals, and the banning and then reinstatement of elective surgery – all occurring much more smoothly and ahead of other states, many of which are still very much at sea.

To end, I'd like to provide you with the points that I gave to a newspaper reporter about the main reasons for South Australia's good results so far:

- the early efforts of the South Australian Chinese community led by a core group of GPs of Chinese extraction
- the outstanding testing regime by SA Pathology, not only in numbers but in the employment of innovative models
- the closure of interstate borders
- the combination of excellent leadership and the willingness of all groups to work together in a depoliticised way in just getting the job done for the sake of the community
- the calm, clear communication to the community who have responded brilliantly.

Again, while not counting our chickens, if South Australia was a footy team, for this first big game the newspaper report would be that 'all played well'.

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The good doctor

Nearly three decades as a South Australian general practitioner made AMA(SA) Councillor Dr Danny Byrne the logical choice as SA Health's GP Liaison during the pandemic.

A younger Danny Byrne when Chandlers Hill Surgery was named the RACGP Australian Practice of the Year

As a six-year-old Mildura schoolboy, Danny Byrne was told by his mother, time and time again, that he should be a doctor when he grew up. The young Danny never questioned the advice; rather, he recalls now, it became part of who he was and who he would become.

With his mother a nurse and father an entomologist, perhaps he would have explored medicine as a career even without his mother's urgings. Maths and the sciences were his favourite subjects at school, and even in art he was most fascinated by the discovery that yellow and blue together formed green.

But because of his mother's insistence, Dr Danny Byrne now 'can't remember not wanting to be a doctor'; nor can he remember ever considering a medical career beyond general practice. 'Yet I didn't know what it meant to be a doctor,' he recalls. 'I've never been a patient, never had a stitch or broken my arm.

'Doctors were doctors, and I didn't know anything else. That seemed fine to me.'

It is a calling that took him through medical school at the University of Adelaide and then his internship, to the then-Family Medicine Program, during which he moved every three months – not every year, as current training programs demand.

At the end of the program he was asked to join Chandlers Hill Surgery, where he has spent most of the past three decades. He has also spent a lot of time educating GP trainees. Most recently, in April, he was seconded to a critical role in SA Health as part of South Australia's response to the COVID-19 pandemic.

He has never questioned his calling. He married fellow student Linda Foreman at the beginning of his sixth year at medical school. They lived 'a poor students' life', young and financially struggling, long hours and hard work, but, he says, enjoyable and challenging. He and Dr Foreman later worked together at Chandlers Hill for 20 years before she left for a full-time role in palliative care. They have two daughters, Sophie and Henrietta, now forging their own careers in arts and anthropology respectively.

'Finally you get to practise what you learned academically,' Dr Byrne says of his intern years. 'Medicine really needs that apprenticeship model – I feel very sorry for this year's "pandemic" students who have been forced to spend months just on bookwork.'

He maintained his passion for general practice through the specialist rotations, conscious that as a GP he would need 'some knowledge about each one, but not a huge amount about any one'. During the Family Medicine program, he was fortunate enough to spend time at The Parks, where GPs such as Paul Pers, Gavin Beaumont and Oliver Frank showed him what to do and how it should be done.

'When you go to different practices during your training, you can see what they're like, how they're different and what's important to you,' he says. 'Chandlers Hill Surgery was a great practice with a really good reputation.'

Since then, the RACGP has named Chandlers Hill Surgery Australia's best practice in 1999 and South Australia's best in 2010. In 2019, patient feedback earned it the Number 1 rating among Australian practices on health appointment booking site HealthEngine.

'Over the years – and no thanks to me – it's become stronger and stronger,' Dr Byrne says of the practice. 'When I joined it had four consulting rooms; now we have 11 rooms with 18 GPs, and nurses and physiotherapy. We do minor surgeries and iron infusions and skin lesions. It's a real medical home now.'

Dr Byrne says the hub model is one development he has supported in recent years because of the time and cost-saving benefits for patients; it won't be long, he says, until a patient will receive treatments such as chemotherapy and ultrasounds at their regular GP surgery. He has also watched as GPs are increasingly able to sub-specialise, so they can provide services such as Type 2 diabetes treatments at Chandlers Hill that previously required visits to the Flinders Medical Centre's Endocrine Clinic.

He has also been an early and appreciative adopter of the technological 'efficiencies' such as My Health Record and electronic prescriptions that are transforming Australian medicine; at the same time, he recognises their value is limited by

the red tape that often limits the transfer of documentation such as referrals between sites. 'Medicine is often the easy bit,' he says. 'Working the system is often the hard bit. Everyone wants to do the best by their patients, but if you don't know the ins and outs of the referral system, it's the patient who suffers.'

Over time, his own interests have developed with his patient cohort. He used to spend most of his time ensuring he had the latest information on paediatrics and obstetrics at his fingertips; now, consultations are mainly about diabetes, heart complications and palliative care.

'As a GP, your patients choose you. And then, if they like you, they stay with you. They age and you age,' he says. 'Any doctor who's been 25 or 30 years in the one practice probably has those regular, loyal patients who've grown older with them.'

Less satisfying is the increased prevalence of mental health issues among GPs' patients. Although he is pleased that more people are willing to present with and discuss mental health issues – especially men – he says there are never enough resources devoted to mental health, or to the role GPs play in helping patients receive the care they need.

Now, in early June, with South Australia's success in battling the virus demonstrated on a curve that 'replicates (his) anxiety levels', Dr Byrne is back in his rooms at Chandlers Hill. He's accustomed to the 25-minute trek south from his inner-city home each day; scarcely notices the drive if the Spotify track or podcast sufficiently captures his attention. He serves his colleagues and his community as an AMA(SA) Councillor. He's looking forward to returning to Adelaide Oval to watch the Crows. And, over the long term, he wants to perform the kind of mentoring role that doctors Beaumont, Frank and Pers did for him, ensuring that junior doctors want to be GPs and are trained to become good ones. 'I'm happy with my career and position and the life it's given me,' Dr Byrne says.

AMA(SA) Councillor Dr Danny Byrne

'But the status of GPs now is lower. The financial remuneration is lower. GPs are undervalued.

'This is an issue of having the best patient care and rewarding that care. We know patients get better faster when good GPs are involved.'

RAH trial aims to test COVID-19 vaccine

Researchers from PARC Clinical Research at the Royal Adelaide Hospital are calling for volunteers to screen for a potential COVID-19 vaccine trial.

Royal Adelaide Hospital Clinical immunologist Dr Pravin Hissaria says people over the age of 18 are encouraged to apply for a possible trial that could result in an historic medical breakthrough.

'COVID-19 has had a devastating impact on the world and that is unlikely to change until we can find a permanent solution,' Dr Hissaria says.

'A number of vaccines are showing promising results in animal models, so we are excited at the prospect of beginning human trials in Adelaide and including others in this exciting journey.'

Researchers are seeking about 100 healthy Adelaide-based adults who would be interested in joining the first phase of the vaccine trial that may start later this year.

Potential participants will undergo a 45-minute screening session, including a review of their medical history and a blood test, to assess their suitability.

PARC Clinical Research's Professor Guy Ludbrook says early screening has already begun, to allow the trial to begin as soon as possible after the trial is confirmed and the vaccine is available.

He says clinical trials on the development of new vaccines, medicines, medical devices and systems of coordinated care – the focus of PARC Clinical Research efforts – have repercussions across the health system, including in avoiding post-operative complications (see page 10).

'The cross-fertilisation of vaccine research with PARC's role in innovation is important, timely, and relevant,' Professor Ludbrook says. 'We want South Australia to lead the way on the development of a COVID-19 vaccine, so we would encourage anyone looking to play a part, to put their hand up and get involved.

PARC Clinical Research's Professor Guy Ludbrook

'By starting the initial screening process now, we will be able to start the trial as soon as possible.'

Professor Ludbrook says the trial is likely to run for six to nine months. More information is expected to be available in coming weeks.

Professor Nicola Spurrier

Dr Tom Dodd

Dr Samantha Mead

Dr Danny Byrne

In the room where it's happening

How has South Australia emerged as a role model for how best to respond to a pandemic? *medicSA* asked some of the medical decision-makers what succeeded and what they've learned.

Joining the conversation are:

- Chief Medical Officer Professor Nicola Spurrier (NS)
- SA Pathology Clinical Service Director Dr Tom Dodd (TD)
- AMA(SA) CEO Dr Samantha Mead (SM)
- SA Health GP Liaison and AMA(SA) Councillor Dr Danny Byrne (now returned to private practice) (DB).

There were some questions that some deemed outside their field of expertise.

➢ ***What was the mood in the health system in February, and how has that changed over time?***

NS: Our mood has always been very positive, at the beginning with a great deal of comradery and people willing to pitch in and do the hard yards. In April it was clear that we were starting to get on top of the numbers, and we had the health system in a relatively good place. It was also clear that the SA community were on board. May and into June has perhaps been more difficult, but not unexpectedly so. Keeping up messaging to people to get tested and keep physical distancing is still important, but perhaps not so obvious for our community as we have had no new cases for such a long time. We knew that making decisions about lifting restrictions would be hard and that has been the experience.

A real bright spot for many of us was supporting the quarantining of a large number of repatriated Australians – the South Australian Indian Medical Association supported this by providing GPs speaking nine different languages – making it so much easier for us to manage the various health issues encountered by this group.

TD: There was a focus on solid and consistent problem-solving methodology to many challenges with short time frames. This approach was founded on good, whole-of-system communication.

SM: Coming into February we were urging the public to be alert, but not alarmed.

In March it was clear that the spread of the virus had to be slowed. The term 'flattening the curve' became part of our everyday vernacular. It was clear we needed to move to shut down events like the Grand Prix and yet there was a reluctance to do so.

April saw significant changes to the way we live and interact. Clear unified messaging, community compliance and a high-level of coronavirus testing all lead to a sense of calm.

May saw reasons to quietly celebrate with no new coronavirus being detected in the state.

DB: In February in General Practice the mood was fine. We were aware of the few cases overseas and the interesting developments in China. In early March we had the Festival and Fringe and WOMAD. It was only in mid to late March that things began to become more real, more scary, and more anxious.

➢ ***SA appears to be one of the few places in the world where science and evidence led (virtually) every decision relating to a response. How did that happen and what difference did it make to the situation we're in?***

NS: From a population perspective, our biggest hero is SA Pathology, which was able to ramp up testing so quickly. Testing and case isolation were key to getting on top of the pandemic. Even in the early days, SA Pathology was doing COVID-19 testing on every respiratory swab.

We have also been fortunate to have academics at SAHMRI provide evidence-based reviews on key topics (e.g., impact of school closures on the pandemic).

At a national level, we have been supported by a truly amazing group of mathematical modellers who have provided detailed jurisdictional modelling to support our public health actions. I have been surrounded by a wonderful team of public health and clinical experts including Dr Evan Everest, Dr Chris Lease, Dr Mike Cusack, Dr Louise Flood, Dr Paddy Phillips and, at critical times, Dr Chris Baggoley.

TD: In terms of pathology, SA Pathology was prepared for a pandemic with immediate testing capacity for 20,000 tests. SA Pathology rapidly responded to the PPE shortage for GPs by setting up the drive-through collection stations – in fact, South Australia was one of the earliest places in the world to do this.

SM: Scientific evidence in Australia is generally well received and the health profession is trusted. Australians overall understand that the benefits of scientific

breakthroughs outweigh any deleterious effects. This general philosophy made Australians willingly comply with the strict social changes necessary to protect the wider community. In the health system there was an enormous amount of collaboration and things that would normally take months to enact or change were happening within hours.

DB: We had excellent leadership from Prof Brendan Murphy on the national scene, Prof Nicola Spurrier locally and Dr Tom Dodd at SA Pathology. I presume the politicians listened because this was a real crisis unfolding before our eyes with alarming real-time evidence from China, Iran, Italy and elsewhere of what was possibly going to happen here. It was not a slow, unfolding issue like global warming and climate change that can be manipulated and ignored - it was real-time crazy real.

- ***What were the strengths of the Australian and SA responses?***

NS: We shut the international borders early and so 'turned off the tap' of new cases. This was complemented early by requiring quarantine for interstate travellers. As the numbers have dropped across Australia, we have been pleased to be able to drop some of these requirements. As noted above, the SA response was exceptional because of the very early, high testing rates. While some states have now caught up, our testing strategy has put us in our current great position. This has been backed up with meticulous contact tracing and quarantining of close contacts. We also moved early to call-out hot spots such as the Barossa, limiting travel into and out of this area and ramping up testing locally. The management of the Adelaide Airport was also a highlight – it showed the importance of partnering with major companies such as Qantas. Turning back a flight from Sydney one evening was certainly not without stress but was done with close weighing up of public health risks. We have also maintained a very strong partnership with our colleagues in SAPOL. This has been of key importance in terms of writing and rewriting the Directions, and of course enforcing the Directions. SAPOL has done a tremendous job with a relatively light touch.

TD: Australia and South Australia were fortunate because of a strong government response at both levels of government, including closing our borders and implementing social restrictions.

In South Australia, we had early and broad testing and contact tracing. This was critical to establish the extent of the spread and assist with case identification as well as contact tracing and isolation

SM: Toilet paper aside, people on the whole were respectful of each other, compliant with the health messaging and courageous in time of great change and stress. The national response to dealing with the virus was calm and clear, and we had the support of the nation to bring about necessary change to save lives.

DB: The response of the community was outstanding. The Australian psyche was tuned in to saving the lives of our elderly and most vulnerable rather than the economic cost. It was very gratifying to see.

- ***What were the flaws in the Australian and SA responses?***

NS: Given that we have done so well, I am not sure we can really find many flaws in the SA response, but we have certainly learned things along the way. We had lots of concerns with PPE supply in the beginning, mainly because of our reliance on overseas manufacture. Some states had trouble ramping up their testing to pandemic levels and there have been supply chain issues with pathology reagents. Our relationships with GPs have improved over time and has been really helped by having Dr Danny Byrne and Dr Emily Kirkpatrick employed in SA Health to facilitate GP liaison.

TD: There were no flaws, but it is interesting to note that Australia is very dependent on many international medical supplies.

SM: There was a real fear that there would not be enough PPE to protect doctors and other healthcare workers. I am pleased to see that Australian companies have come on board to make quality locally produced PPE to ensure there is fit- for-purpose equipment in the future.

DB: Easy to say this in hindsight but we did not have enough PPE for the whole health system. I think General Practice has to realise that they need to be self-sufficient and better prepared on a local individual level. The few practices that had their own prepared stored PPE supplies were at a major advantage. The thought that you can just rely on government is not realistic any more. The other issue in the early days was the mixed messages from each state. Once the national consistency kicked in it was much easier to promote consistent messaging.

- ***What was the importance of testing to SA's response?***

NS: The World Health Organisation urged countries to test, test, test to control the virus and testing has been the backbone of South Australia's response. We would not be in the position we are in today if it weren't for the quick and innovative response from the team at SA Pathology. In early February, our laboratories established local testing and we added the novel coronavirus testing to routine respiratory infection testing through GPs. While this not only made it a more efficient and streamlined process for GPs, it also meant we could rule out any incidental links to COVID-19 within the community. Once our testing capabilities were improved, we wanted to make it easier for South Australians to get tested. We introduced a domiciliary service, dedicated COVID-19 clinics, and were among the first in the world to establish a drive-through clinic. While initially our testing was targeted to people who met the clinical criteria, we were very excited to launch a testing blitz in mid-April to gauge the level of infection within the community. The blitz reiterated in my mind that we had very little COVID-19 within the community, which was a pleasing result. Overall, the extent, accessibility and innovation of SA Pathology's testing throughout the pandemic has been world-leading and left us in very good stead.

TD: This was very important to establish the extent of the spread and assist with case identification and contact tracing and isolation.

- ***If you could change one action between 27 January and 9 June, what would it be?***

DB: Close the international arrivals to all countries. We were quick on China and Iran but too slow on Italy and US. And cruise ships - no way next time. They must be the first to shut down!

SM: I guess this depends on what state of Australia you live in. If you asked someone in NSW, they might refer to the disembarkation of 2,600 passengers from the Ruby Princess cruise ship. From my point of view it became clear that we knew we had to stop many of the things we enjoy, like sport or dining

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A specialist's story

The COVID-19 pandemic has hit every South Australian doctor in unique – but also shared – ways. AMA(SA) Councillor and haematologist Dr Shriram Nath provides his perspective.

Dr Shriram Nath

I came to know about coronavirus when it was announced in faraway mainland China. I felt that pandemics similar to the coronavirus had been contained within China in the past and that this would occur with the coronavirus, too. Every year the Chinese New Year changes and a new virus emerges and subsides. Life outside China seemed to be going on at a steady pace. I had no idea what is going to hit me in the coming days. I had no prior experience to prepare me for the change.

In early March 2020, the pandemic started to spread beyond the shores of China. I received an email from the organisers of a thrombosis conference to be held in Singapore in May 2020, telling me that the conference had been cancelled due to the coronavirus. I started to realise that the virus was going to affect me and change my life.

Soon, Australia's Prime Minister announced that air flights from various parts of the world were being cancelled. Various experts appeared on television and radio, predicting what the path forward would be. Businesses were closed as virus cases came to light in Australia. I realised I was in the health sector, running a small business. Will I survive the pandemic? Will my business and its two staff survive? Preparations started, searching for masks. Everything was in short supply, even (especially) toilet paper. The practice had difficulty sourcing masks and hand wash. 'Social distancing' and 'flatten the curve' dominated our language.

People listened to the Prime Minister and the Chief Medical Officer. They stayed home, postponed going to their General Practitioners. Community blood tests decreased. Diagnosis of haematological problems was postponed, along with that of other problems. Sitting in the doctor's chair was a different feeling. The number of patients turning up to the clinic decreased while phone consults increased. Some of my patients wanted to discuss with me 'flatten the curve' and 'R-value'. One of my elderly, long-term patients told me on the phone that he and his wife had been 'read the riot act' by his children so they were remaining within the confines of their home awaiting for things to improve. Returning Ruby Princess cruise passengers and close contacts of COVID-19 on the aeroplane to Adelaide narrated their experience of the ship and the quarantine process. There was anger and helplessness – but also hope. Once the curve started to flatten, everyone saw the reason for their efforts.

... the only employment option was to enrol in the SA Heath COVID-19 health recruitment drive for private practitioners ...

Meanwhile, for us, even though patients were not in the clinic, administration tasks and time remained the same. Arranging follow-up radiology, blood tests, and appointments with other specialists, hospital admission and getting back to the patient on the phone was a different experience. Telehealth and phone consults had become the new norm and possible because phone lines were working. No electricity shortages were noted. Stamps were not in short supply. Australia Post was used to send follow-up blood test forms to patients.

Conferences were cancelled. Zoom/Microsoft team meetings became a norm. Listening to international speakers in my pyjamas (because of time differences) was not so boring. Multidisciplinary meetings were initially a technology challenge but became the norm of the day. Gaining knowledge without the hassle of travel was welcome.

Private hospitals struck agreements with government for nursing staff and beds. But individual private practitioners and practices such as pathology and radiology services were not included in the agreements. The only employment option was to enrol in the SA Heath COVID-19 health recruitment drive for private practitioners, and possibly gain employment if required during the pandemic. Various medical indemnity insurance companies were contacted to clarify the status of treating public patients in private hospitals. SA Pathology was given a lifeline by the government during the pandemic, which was a relief. Clinpath Laboratories joined the battle with COVID-19 testing. 'We are in it together' was the sentiment.

The lack of personal protective equipment (PPE) led to the closure of elective theatre lists. Opthalmology clinics were closed. Medical practitioners and practices were exploring the government's JobKeeper allowances and cash-flow support programs.

Taking rounds in hospitals was different. Temperature checks were performed on doctors as we entered, stickers stuck on our clothes, visitors restricted. PPE equipment like masks was kept under lock and key as they were in such short supply. Everyone was aware that they must save PPE. Some hospital coffee shops were closed by their franchise owners. Others offered takeaway, so we could inhale vital

caffeine but not sit in the coffee shop and share a discussion with a colleague.

Social distancing applied to travelling in lifts, with two per ride. Consultation was limited to having the patient in the room and using technology to include relatives in the discussion. Theatres were empty with only emergency operations and procedures being performed.

And all through this, there was the fear of the unknown. The fear of contracting COVID-19 and not able to deliver health care was always on my mind.

Now, as I write this, the situation has improved, restrictions are being relaxed, people are feeling a lot better as South Australia continues to record no new cases.

I have adopted the motto 'The aim of 2020 is to survive, and all the rest is a bonus', as a famous person said. My business, staff and I survived March, April and May largely due to the support of my patients, and colleagues; my GP; my family and my faith. 'Australia is a lucky country' is making sense for the first time. With luck and continued good management, we will remain so.

AMA(SA) Councillor Dr Shriram Nath is a clinical haematologist consulting at Adelaide Haematology and in hospitals, and also works at Clinpath Laboratory in Adelaide.

In the room where it's happening ...

... continued from page 19

out, but slowing the spread also meant slowing the economy and there was a pivotal time when we could have closed things down earlier.

➢ ***If there is one outstanding benefit to have emerged from the pandemic, what is it?***

NS: The health system has worked remarkably well together throughout the pandemic. From weekly webinars with GPs through to daily communication across the public and private sector and Residential Aged Care Facilities, the engagement, cohesion and cooperation across all sectors involved has been a benefit not only internally but to all South Australians. I hope we continue to work in a much more aligned and consistent approach from here on in.

TD: The creation of the GP liaison role in SA Health.

SM: It is understanding that we can move quickly by whatever means to enact change for the greater good.

DB: For General Practice, the use of telehealth. It seemed like 10 years of lobbying and wish-lists for common-sense use of telehealth came into being overnight.

➢ ***What have you learned – about yourself, about the system, about human behaviour?***

NS: The system – covered above and below.

I have been amazed at the cooperation, generosity and compliance of South Australians. In January we faced an unknown future and we had to make changes quickly to protect the health of our community. I didn't expect such a positive response from the community. I have been overwhelmed at the letters and emails of thanks I have received throughout the pandemic.

TD: I appreciated the collegiate approach of all involved, from members of the public to the people required to make essential health decisions very quickly.

SM: I have learned a lot. The past couple of months made me reflect on how stretched for time I had been. Moving from meeting to meeting or children's sporting events meant that I was constantly on the go. Everyone being forced to use technology to get things done has been a real positive.

DB: We can act quickly and rationally when we must if we have the right people in charge. I also learned that some people still wanted to do 'business as usual' with committees and meetings, which was just not OK in a crisis. How we all reacted personally when we were genuinely in a crisis is understandable – it brought out the best in most people.

What has the SA health system learned?

NS: During the pandemic, the health system was forced to adapt rapidly and respond very quickly to an ever-changing situation. These are the characteristics that we want to take forward into our business as usual approach as we build a dynamic and world-leading health system. From our hospitals to our Communicable Disease Control Branch, the system has learned to work very well together and the excellent work so far has put us in a very good position for any further outbreaks in the future.

SM: Rather than learned I would say reinforced. It reinforced that our health system can be nimble and work collaboratively to ensure massive change in minimal time.

DB: Not for me to say but I really hope SA Health learned that bringing in Liaison GPs (Dr Emily Kirkpatrick and me) was a very clever move and they would do the same again next time. The positive feedback from grassroots GPs to the service we provided has been humbling and overwhelming.

➢ ***How strongly should the AMA push for a national Centre for Disease Control (CDC)?***

TD: South Australia's success highlights the important role of the SA Communicable Diseases Control Branch.

SM: Australia is the only OECD country without a national centre for disease control. In the case of coronavirus, we seem to have taken control of the spread of this virus despite not having a CDC and so there might be those who say 'why is a CDC necessary?'. But for me having a CDC is a no brainer. After witnessing what has occurred globally because of coronavirus it would seem inexplicable to not establish a body to, among other things, gather data to predict and monitor public-health threats, and accelerate information flows.

DB: The AMA should be lobbying for a CDC now – and as strongly as possible. A pandemic will happen again, and we need better national coordination from the start next time.

A model for future pandemics

Orthopaedic surgeon Professor Ted Mah is determined that the challenges endured in this pandemic will provide lessons for the future.

The worst of the pandemic may be over but there is more to do to overcome time lost for patients and to evaluate the COVID-19 strategies for future emergencies, says the Head of Orthopaedics at Northern Adelaide Local Health Network (NALHN), Professor Ted Mah.

Professor Mah says that having managed contingencies from shortages to potential infections among staff, medical teams now have a solid blueprint for future pandemic responses – one he's keen to share with colleagues.

'This won't be the last pandemic we experience and there is a lot we can learn. We need to identify what works and what doesn't, and to create a template as a way to safeguard the future,' Professor Mah says.

With careful planning and management of personal protective equipment (PPE), emergency orthopaedic surgery had continued throughout the pandemic, he says. Outpatient consultations were conducted by phone and junior doctors continued to train.

But cancelling elective surgery had caused ongoing problems that would continue for months and possibly years.

'Because of the restrictions in providing clinical services for patients, there is much longer waiting time,' Professor Mah says. 'Nothing has changed in the public hospitals. The fact you don't see 50 patients a day in a clinic doesn't mean they've gone away. They are just backed up in the hospital queue.

'We already have a lengthy waiting time for the Orthopaedic Outpatients Department even before the COVID-19 crisis started, and now, after four months, we have even more people on the waiting list. Patients still need treatments irrespective of COVID, and this is the social price that our community has to pay.'

Imported supplies such as medications were limited by air transport restrictions, creating further delays in ramping up elective surgery, Professor Mah says. At the same time, local manufacturers that rushed to produce PPE in response to government subsidies were likely to be stuck with an oversupply. 'Once all our hospitals are fully stocked with PPE, Australia should donate surplus PPE to other areas of need, places like Africa, parts of Asia or Pacific Islands,' he suggests.

Managing the private health insurance fall-out associated with mass unemployment will also be an issue, Professor Mah says. He suggests some people will stop paying for private health insurance, while others without insurance will defer treatment because they can't afford it.

'People will rush to have surgery before their private health cover expires, but they are unlikely to renew their private cover,' he predicts. 'There'll be fewer people who can afford to take on private health insurance, if they have lost their employment.

'The government could consider providing some tax concessions for people paying private health fund to prevent job losses in private health

providers and reduce the burden on public hospitals.

'The government should also consider increasing the Medicare rebate. At the moment, patients have to pay a gap because the rebate has not kept up with inflation over the past 20-plus years. 'After the JobKeeper scheme finishes later in the year, why don't we consider putting some of that money into health care?'

BATTLE BLUEPRINT

Professor Ted Mah and his colleagues developed what they call an 'Orthopaedic Surgery Pandemic Blueprint' that he's keen to share to support preparations for future outbreaks.

Key plans included:

- Promote and ensure staff and patient safety
- Inform staff about evolving clinical guidelines and assess institutional capacity
- Develop clear policies for airway management in known or suspected COVID-19 patients
- Maximise patient wellbeing to allow early discharge
- Establish rotating teams that communicate regularly but can work in isolation
- Enable senior consultants to support and advise junior medical officers
- Engage department staff for meetings and teaching via videoconferencing
- Postpone elective surgery and plan for phased return
- Introduce telephone and telehealth consults where appropriate
- Aim to continue acute orthopaedic admissions where possible (these were only slightly reduced from pre-COVID).

Emergency procedures

The following measures were introduced for emergency surgery:

- A protocol for senior consultants to prioritise surgery cases first thing in the morning
- Clear policies for airway management in known/suspected COVID-19 patients
- Dedicated COVID-19 or modified operating room: 1) away from high traffic areas; 2) with few people present during anaesthetic induction and extubation; 3) negative pressure where available (positive pressure and air conditioning switched off)
- Independent flow pathways for traffic in and out of designated COVID-19 operating theatres
- Day-case surgeries where possible, aiming for early discharge and single-staged surgeries
- Surgical interventions if their documented effects are superior to non-operative management. Benefits and harms discussed with patients.

Elective lists

Only Category 1 or time-expired cases, with a surgical review committee to screen and prioritise cases.

Outpatients

- Waiting rooms redesigned to follow distancing rules
- Patients screened and relatives advised not to accompany patient to the consulting rooms unless absolutely necessary
- Most consultations conducted by phone
- Consultants rostered to Outpatients Department (OPD) (either in person or on phone) to provide immediate advice on treatment plans and reduce the need for patients to return to OPD.
- All registrars to treat trauma/emergency referrals/patients via telephone consult, with consultant advice where possible
- Clinicians advised to use splints rather than plasters or backslab.

Older patients from residential care

Patients with suspicious symptoms such as coughs were swabbed for COVID-19 in the Emergency Department and treated as planned if indicated. Those confirmed with COVID-19 were transferred to the COVID-19 designated hospital (the RAH).

Teams

Surgical teams were split into three rotating teams that would communicate across teams by phone, Zoom or Microsoft Teams.

Two teams performed different duties and one team remained at home, ready to step in if a member of one of the other teams was exposed to COVID-19. These teams were rotated.

Team 1 was responsible for ward rounds and in-patient care, emergency theatres.

Team 2 was responsible for the Modbury Private Hospital and Lyell McEwin Hospital outpatient clinics. Clinics were reduced and mainly conducted by phone. Team 2 triaged all emergency department referrals in the mornings.

The overnight registrar could be from Team 1 or Team 2 - daily handover was via Zoom at 7.30 am with consultant input.

Team 3 – later became the Modbury team. Initially this was the standby (clean) team.

Interns – all interns attended hospital daily and rotated with the RMOs for cover shifts.

Where allocated OT sessions were cancelled, consultants came to the hospital to provide leadership and to support Junior Medical Officers where possible. Registrars to remain in their current rotation until 2021 to ensure they achieve the required clinical experience.

PPE

All gowns, masks, face shields, wipes and alcohol gels were kept in secure areas. Supplies of PPE were initially low but weekly ordering was implemented based on demand and increased manufacturing, which meant the shortage was short-lived.

Nursing staff

Nursing staff used appropriate PPE when required and ensured they maintained their hand hygiene. Where possible, they carried out duties while maintaining distancing. The arthroplasty education sessions that nurses run with physios were temporarily cancelled.

Medical staff teaching

Weekly Zoom teaching sessions replaced face-to-face from March 2020. Face-to-face teaching resumed with relaxing of restrictions, but with physical distancing and Zoom as an option.

Working from home

Staff working from home were asked to provide brief logs or descriptions of their activities, e.g. telephone consultations, telephone supervision/teaching, mandatory training, professional development and research, etc.

Telehealth

From late May 2020 telehealth templates commenced, including approximately one third face-to-face, one third telephone consultation, and one third telehealth in all orthopaedic outpatient departments.

Waiting lists

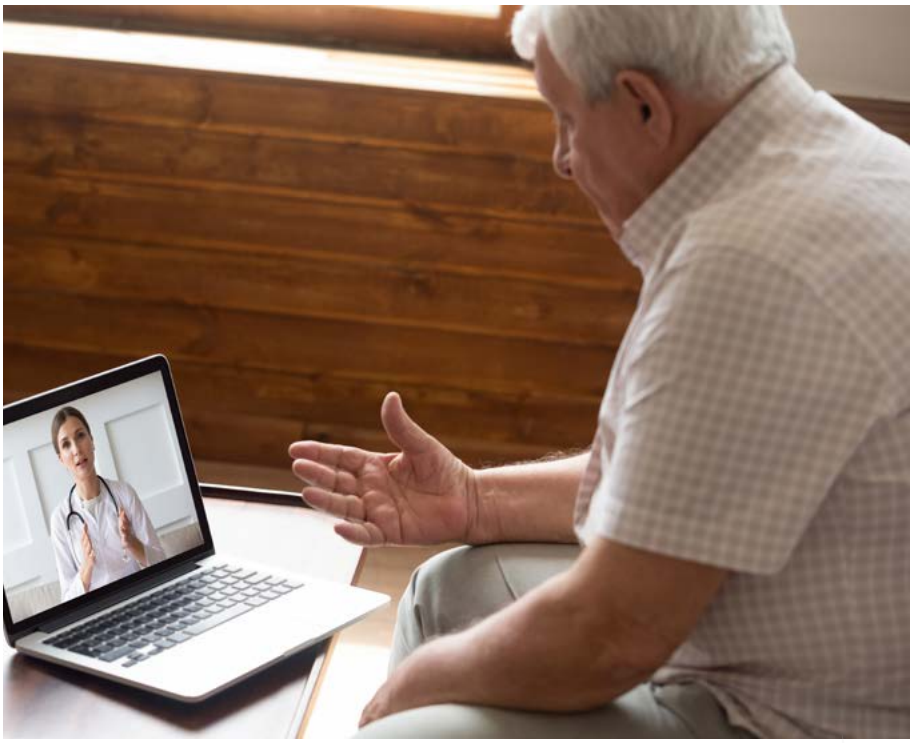
Phased return of elective surgery planned, including potentially outsourcing procedures to appropriate private hospitals to help to clear the backlog.

Health and Wellbeing

All staff was reminded to rest well, eat well and practice vigilant hand washing, social distancing and if appropriate use gloves, gowns and masks.

Loud call for telehealth

COVID-19 has finally released the telehealth genie from the bottle.



With some recalibrations and a newfound impetus to develop technology, the telehealth innovations introduced during the pandemic could have great benefits for patients and change the way health is delivered, says AMA(SA) President Dr Chris Moy.

Dr Moy represented the AMA federally on the initial 2010 Department of Health and Ageing Telehealth Advisory Group and is a Clinical Reference Lead for the Australian Digital Health Agency. He says that progress on achieving a Medicare rebate for video consultations had largely stalled for 10 years due to hesitancy within the Department of Health.

'COVID-19 forced the hand of the Federal Government in implementing temporary Medicare rebates for telehealth services,' Dr Moy says.

'Telehealth consultations were never meant to replace face-to-face – you can't set a broken arm or lance a boil via telehealth. But during the pandemic, it reduced the possibility of COVID-19 spread by decreasing physical contact and reserving face-to-face consultations for when they were necessary. Otherwise, if a patient came into a clinic with the virus, you would have to close the whole place and isolate all staff.

'Now that patients have had their eyes opened to the advantages of telehealth – especially those with mobility problems such as the aged or those with disabilities – the option to use telehealth where appropriate is here to stay. Everyone will fight for it, including the consumer groups that are behind it.

'I think people see now that it's ridiculous to make people come in for consults that could be handled via video or over the phone, which is what Medicare requirements have artificially forced for so long.'

However, Dr Moy says, there have been problems, primarily because the Medicare items were created quickly to respond to immediate need.

'Because there had been no progress with these items, we weren't ready with the technology,' Dr Moy says. 'The crisis has forced this and that's been a good thing.'

He says that while video technology apps such as Zoom, Skype Facetime and WhatsApp do not yet technically meet privacy requirements, the introduction of telehealth item numbers will prompt developers to produce appropriate health apps that will be easy for both practitioners and patients to use and connect with each other.

'In the future,' he says 'you can expect to see family practices using software and apps that enable their patients to consult much more seamlessly with their doctors electronically – while ensuring improved privacy and security – so that they'll get a message telling them that the doctor is about to call them.

'Patients may even be able to take their blood pressure and other measurements, as well as photographs, which can feed directly into the app to be sent to their doctors in real time and securely.

'In addition, we've implemented technology to send prescriptions electronically – we're just waiting for the legislation to be finalised.'

At the same time, he says, there will need to be regulatory changes to prevent the unethical behaviour that has already emerged: pop-up telehealth services including those promoted by pharmacies that advertise telehealth services solely to provide prescriptions.

'These cases represent a perverse "tail wagging the dog" and totally contradict the principle of doctors only prescribing based on clinical need,' Dr Moy says. 'The telehealth item numbers will have to be adjusted to minimise this inappropriate and unconscionable behaviour, to ensure telehealth is used only as a part of providing high-quality care.

'It's the 21st century. We have the technology. But we also have many patients suffering from chronic illnesses. Telehealth will be particularly important for people with mobility or transport challenges or people living in rural areas. It will also help reduce infections if COVID-19 remains a threat to community health.

'We should encourage people to only come in if they want to or have to, while ensuring the highest quality of health care. That's the future.'

The lighter side of telehealth

Dr Michelle Atchison has found that telehealth has produced some unusual consultations – including at Bunnings.

Psychiatry had been a major up-taker of telehealth before the coronavirus and was using it to good effect to give consultations to rural and remote areas. The coronavirus took us all by surprise, with a rapid uptake of telehealth for all consultations. I think it took some patients by surprise as well! As is the case for many doctors, I have had to use the telehealth platforms that were easily accessible and which patients felt comfortable with. This has meant a number of consultations by Facetime, Skype and WhatsApp.

Not all consultations have gone to plan. As time has gone on, it has seemed as though some patients have forgotten the meaning of a consultation. A number of times I have called, only to take the patient by seeming surprise. (We do remind patients the day before by text that they have an appointment). During this COVID time I have done many consultations while people are driving somewhere in their car. That is okay, (kind of), until the recent consultation where someone propped their phone up on the dashboard and tried to say it was alright to do a Facetime call as they were driving! I have had consultations while people are out walking their dog, digging in the garden or cooking. Having a psychiatric consultation where I later find out the person is walking through the shops, especially Bunnings, has become common. Many patients have had to retreat to a car, or one to a caravan in their yard, to have privacy for their calls.

While the nice part of telehealth video consultations is that I often am able to walk around a person's house or a look at their dog or children, there are some sights that can't be unseen. One woman finally worked out how to use Facetime, only for me to see them sitting there in only their bra! As anyone doing telehealth would know, the number of close-ups of nasal passages, ears and under-chins is incredible. One sensible patient used a selfie stick and I would have to say it gave a very good picture.

Telehealth also allows the doctor to consult in a different way. We are all far more aware of our hair (which was a problem when we couldn't go to hairdressers) and what is behind us on a videocall. Unlike Zoom, none of the platforms I was using have virtual backgrounds, so having my familiar office painting behind me I hope gave some sense of connection back to my office for patients who were missing coming in. I have been very grateful that I can wear my ugg boots to work in this recent cold snap with no judgement. At least I have had more on than just my bra!

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

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The greatest relief

Innovative support has helped consumers of palliative care in the pandemic.

Palliative Care Clinical Network Clinical Lead Dr David Holden

They say it takes a village to raise a child and, equally, it often takes a community to make the end-of-life experience comfortable for terminally ill patients and their families.

And for this to happen, there need to be seamless support and transition between services –not always easy given the complex web of federal, state and community services involved.

That's why the new Statewide Palliative Care Clinical Network Steering Committee, formed in late 2019, includes clinicians, community service providers and consumers, with a strong co-design focus to improve the consumer experience.

Palliative Care Clinical Network Clinical Lead Dr David Holden says the 19-member committee, created under the auspices of SA Health's Commission on Excellence and Innovation in Health (CEIH), has the consumer links necessary to ensure service providers can offer the seamless support people need.

Dr Holden says there is opportunity for the committee to improve the experience and outcomes of palliative care for consumers, carers and the community, whether at home, in residential care or assisted living, or in the hospital system.

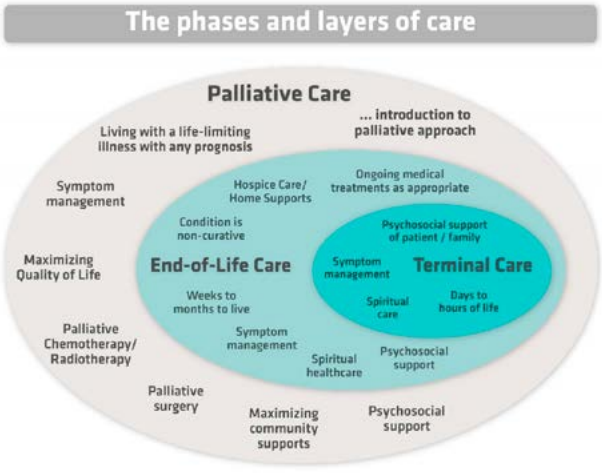
'What you find is that by taking the consumer lens, it helps us collaborate around a common goal,' he says.

Dr Holden says the committee has started a co-design process that uses creative design thinking from the end-user's perspective to develop a cohesive, interdisciplinary service plan. Sub-committees focus on factors such as grief and bereavement, core medicines, Aboriginal palliative care and rural support services.

'There is a recognition that specialist palliative care has an important role in supporting generalist palliative care, but most is provided in the community or by generalist palliative care,' Dr Holden says.

'Some of the issues identified by patients and carers in a state-wide workshop last year include the need for access to services, particularly after-hours support. Patients and their families are looking for easier access to resourcing to help them support the loved one in the site they want to be.'

Dr Holden says the committee is building on collaboration between the state and federal governments in the $7.65 million Agreement on Comprehensive Palliative and Aged Care and the state government's $16 million palliative care election commitment. SA Health is expanding community outreach services to provide a 24/7 service and a phoneline to help clinicians access specialist support has been created.



Dr Holden points to recent research by Palliative Care Australia that found that community support for advance care planning, which captures a person's values and beliefs to inform medical decision making, is valuable for the individual and the family and creates economic benefit for the community.

'There is growing recognition around the need to support palliative care,' he says. 'In a short time we've seen some great examples of collaboration in this space and there has been a range of new supports to improve the experience of consumers, families and clinicians such as GPs, nurse practitioners, and palliative care community nurses.

'In telehealth, for example, particularly with the restrictions and limitations around visitation during COVID-19, we've seen extensive uptake of telehealth to provide support for patients with an emphasis on supporting rural colleagues. Face-to-face visits still occur but these have been supplemented and replaced with telephone and video telehealth.

'Caring-at-home kits have also been developed, and fact sheets for pharmacological and non-pharmacological symptom management have been particularly helpful in rural settings where 24/7 services are difficult to provide.'

Dr Holden says the Rural Support Service, SA Health, CIEH and AMA(SA) have been very supportive in advocating for a consumer-focused approach to palliative care.

'I am also thankful that there is an approach to palliative care that considers not only the medical needs but the broader community aspects – for example, through advance care planning and grief and bereavement support,' Dr Holden says.

'There is a lot of great work to be thankful for around palliative care. There are still some significant issues to tackle, though, including workforce and education, not only in the specialist services but recognising the role of palliative care in the whole health system ... (and) that different community members will require different levels of support from different services.'

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Protecting the vulnerable

Close attention has been paid to managing the needs of vulnerable Aboriginal communities during the pandemic, write Shane Mohor and David Scrimgeour.

Australia, and South Australia in particular, has done well with the public health response to the global pandemic of SARs-CoV2.

Border closures, widespread testing, active contact tracing, and measures to limit viral transmission have flattened the curve to the extent that in South Australia, at least for the time being, there is apparently no community transmission.

Three months ago, with the initial wave of infections, there were legitimate concerns that Aboriginal communities would suffer disproportionately from the pandemic.

High levels of poverty, overcrowded housing and homelessness in a highly mobile population increase the risk of widespread transmission, and higher rates of chronic diseases and other co-morbidities increase the risk of severe disease and death.

The spread of COVID-19 in Australia has meant that, so far, these fears have not been realised, with no cases yet reported in Aboriginal people in remote or very remote parts of Australia, and no Aboriginal deaths from COVID-19.

However, the vulnerabilities remain. With the easing of restrictions, cases of COVID-19 will inevitably re-emerge and there is the possibility of the introduction of the infection into Aboriginal communities, with potentially devastating consequences.

The current period of quiescence in the pandemic at least allows steps to be consolidated to minimise the risk of this happening.

The Aboriginal health sector, and other Aboriginal organisations, were proactive early in the pandemic in introducing preventive measures. Some Aboriginal community organisations in South Australia introduced restrictions on travel to and from their communities before the Commonwealth Government amended the *Biosecurity Act* to further support these restrictions.

South Australia's Aboriginal health services moved quickly to update their pandemic plans ensure policies and processes to appropriately manage patient flow with physical distancing, triage and to identify suspected cases and facilitate timely testing.

There were some initial difficulties in obtaining personal protective equipment (PPE) from Primary Health Networks, but the Aboriginal Health Council of SA (AHCSA) worked with SA Health to ensure a direct supply of PPE from the state's stockpile to Aboriginal community-controlled health services.

AHCSA has also worked with these services to assist with planning and training to ensure that best-practice infection control policies are implemented.

Like many other primary health care services, Aboriginal health services increased their use of telehealth. In fact many Aboriginal health services had been using forms of telehealth for years (especially in remote communities where there may not be a GP on-site at all times), but without the benefit of Medicare rebates, so the recent introduction of telehealth rebates was viewed by these services as well overdue.

Another important development has been the introduction of Point-of-Care testing for COVID-19 in some Aboriginal health services. This is a response to the recognition that in more remote areas, waiting for a swab result can take a week or longer, with the patient often unable to adequately self-isolate during this period and potentially infecting many others if positive.

The Commonwealth Government has funded a national program to establish Point-of-Care testing in selected rural and remote Aboriginal health services, including in South Australia. This has reduced the waiting time for swab results to about an hour.

Despite these positive developments, many Aboriginal health services continue to have legitimate concerns that more remains to be done, and to express frustration that there has been an inadequate response from state government departments to these concerns.

Planning has been centralised within government, with insufficient involvement of the primary health care services on the ground, with local public health and socio-cultural knowledge, which should be informing the planning processes.

This reluctance of government to engage with and respond to Aboriginal organisations is exacerbated by the fact that the Aboriginal Health Division within SA Health has been cut back in recent years, leaving it under-resourced and unable to provide the direction and leadership required (despite valiant efforts by the overworked personnel involved).

A South Australian Aboriginal Communities COVID-19 Action Plan is yet to be finalised. When completed it will provide a state-wide framework, but it is critical that detailed planning progresses now at the regional/local community level. While this has happened to some extent (mainly within the Aboriginal community-controlled sector with little government involvement) there are no detailed response plans outlining support requirements and clearly defined roles and responsibilities.

Importantly, this includes detailing the role played by SA Health and the State Control supporting agencies to enable a rapid, effective outbreak response. And while remote communities are a priority, given the potential for a greater health impact from an uncontrolled outbreak, this work also needs to be undertaken in non-remote Aboriginal communities.

This local-level planning is especially urgent as we move to ease restrictions for the general population as well as easing restrictions for Aboriginal communities, which are part of the Biosecurity Act Determination. The ability to manage a COVID-19 case rapidly to prevent and contain an outbreak will be critical in supporting communities to manage these risks and to minimise future outbreaks.

Without a more effective and inclusive response from the South Australian Government involving Aboriginal leaders and organisations, there is ongoing potential for a significant mortality rate from COVID-19 among South Australian Aboriginal people. Black lives matter here, too.

Shane Mohor is CEO and David Scrimgeour a Public Health Medical Officer at the Aboriginal Health Council of SA.

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Collaboration the legacy of COVID-19

The 'one for all' attitude that doctors are demonstrating must be a lesson from the crisis.

Surgery in the pandemic has demanded co-operation between all health practitioners

As a profession, surgery has a reputation for being highly competitive (not to say cut-throat).

Yet South Australia's COVID-19 response has brought the profession in the state together in a rapid and constructive way to protect the local community, says vascular surgeon Dr Peter Subramaniam.

From the vantage point as a medical lead in the surgery program at Central Adelaide Local Health Network (CALHN), as well as a vascular surgeon in private practice, Dr Subramaniam has a bird's eye view of the impact of the pandemic on the profession.

He admits it has been personally challenging on many fronts: as one of many clinicians contributing to rapid decision-making in the South Australian public health system, as a private practitioner, as the father of teenage children at university and senior school, and as a son whose 91-year-old father lives in Malaysia.

Yet, he says, there is cautious optimism about the COVID-19 response.

South Australia's health care system, already in a strong position before the crisis, would be even stronger, he says.

'What we have realised is that we (surgeons) have a reputation as competitive individuals - but when the chips are down, as they have been, we've been able to band together, easily and with a sense of a common goal,' Dr Subramaniam says.

'For us in CALHN, we were on a process of financial recovery. We had put some measures in place to make us more accountable and, in some respects, COVID-19 has accelerated that process. It has given us unity of purpose; it has brought us together – not only surgery in CALHN but as a medical community and not just within Australia but internationally.'

He says the crisis has highlighted the interdependence of health, community and financial systems in a way that would encourage people to better share information in future. Doctors from all over the world were looking beyond self-interest, sharing data and strategies in on-line forums across multiple time zones for the common good.

And while there have been stories about the theft of personal protective equipment (PPE) and hoarding, he says that for the most part, the crisis had 'brought out the best in people'.

Surgeons had generally accepted, with good grace, the hit to private practice caused when elective surgery was suspended to preserve a precious PPE supply in anticipation of a surge of demand.

Surgery at CALHN rapidly developed a simple algorithm to find the balance between essential and non-essential surgery: surgery would be conducted if it were in the best interests of the patient, if it could be conducted safely for the patient and the staff, and if it were of community value.

Meantime, private surgical practices had kept their doors open where possible, providing reassurance as much as clinical care in physical consultations and via telehealth to patients who needed it.

Yet some difficult decisions had been necessary, nearly spelling the end for many private and small community hospitals before governments waded in with emergency support packages to preserve the delicate public/private ecosystem on which Australian health care depends.

This was thanks in no small part to lobbying by the AMA, Dr Subramaniam says.

'We are now reflecting on how to bring us together, and when we are through this, how we retain some parts of that thinking to develop a "new normal" in surgery but also across all medical specialties and community care,' he says.

'We have now experienced something that other countries experience all the time: infectious disease with no antibiotics to treat it, no health care facilities. We have everything but, as a community, we are reeling because we have never been in [a pandemic situation] ourselves – we have just read about it.

'Now we have some experiences, we need to do something with it. I am very interested in the impact this has on the next generation of doctors, nurses and health care workers.'

Dr Subramaniam hopes a sense of interdependence across the community will become the new norm, along with a commitment to ongoing improvements to systems, rapid access to scientific data – and continual handwashing.

'I think the crisis has brought out the best in in the medical profession,' he says. 'People have died in Australia, thousands have died across the world; I think it is a big cliché to say this, but those deaths should not be without some learning for all of us.... we have realised how capable we are to deal with it and that's a strength.

'There is a quote that really impressed me from the President of the World Health Organisation, just after America withdrew funding. He said: "This virus is a very dangerous virus because it infects the space between us".

'That is true – but here, we've done well because we have supported each other.'

AMA supporting DiTs during COVID-19 response

The AMA has been working to ensure that both patient and trainee safety is at the forefront of any decisions during the COVID-19 response.

The Federal AMA has been talking to medical colleges and regulatory authorities about how to support doctors in training (DiTs) and mitigate the impact that COVID-19 will have on medical education and training over the next 12 to 18 months.

State and Territory AMAs and the AMA Council of Doctors in Training (AMACDT) have been supporting DiTs in highlighting and addressing industrial issues as they arise.

Given the rapidly changing environment and competing priorities surrounding the impact of the COVID-19 virus, the burden on doctors in training and the implications for education, training and clinical care have required careful consideration. Some trainees have had their exams cancelled and disruptions to other training activities are likely.

As the situation with COVID-19 has altered, a pragmatic and flexible approach to medical education and training has been required. Among the concerns for DiTs has been ensuring that those who are asked to work outside their usual clinical area/role or scope of practice are given appropriate induction procedures, supervision and PPE.

Similarly, DiTs have sought reassurance that consideration must be given to the level of work, stress, difficult clinical treatment decisions and large numbers of ill patients which may impact their wellbeing, along with the health and wellbeing of all frontline healthcare workers.

The AMACDT quickly developed an online resource to help specialty trainees stay up to date with the status of Colleges' responses to the COVID-19 pandemic.

The resource summarises publicly available information from individual College websites about changes to, and the current status of, assessments, education and training, selection into training and wellbeing. It includes links to College COVID-19 webpages and to pages targeted at trainee wellbeing. This resource provides information in the following areas:

For specialty trainees

- examinations
- career progression
- exam, course and other fees
- special COVID-19 leave
- wellbeing

For prevocational trainees

- application processes for training.

For more information go to the AMA website.

Feet first!

AMA(SA) Councillors, staff and members have been promoting #CrazySocks4Docs throughout June.

The 2020 #CrazySocks4Docs campaign began with an online launch and webinar led by campaign founder Dr Geoff Toogood on 4 June.

#CrazySocks4Docs highlights that who just like any person can also suffer the full range of mental health issues – anxiety, depression, burnout, fear, anger and more – and that they must be able to seek help without fear of embarrassment, humiliation or effects on their ability to practice medicine.

With Doctors' Health SA, we've maintained the effort in the weeks since, showing off our crazy socks – and in some cases the dogs who seem to love them! – on social media.

The paradox of isolation

A 'nobody left behind' approach is guiding pandemic strategies at Flinders University.

It's a commonly observed paradox that intense social dislocation associated with the global COVID-19 pandemic has simultaneously been a force to bring communities together.

That is exactly what has happened with the 4,000 staff and students at Flinders University's College of Medicine and Public Health, says its Vice President and Executive Dean, Professor Jonathan Craig.

Across campuses ranging from Mount Gambier to Nhulunbuy in the Northern Territory to the expansive multilayered campus at Bedford Park, a sense of common purpose and creativity has forged stronger bonds.

The university adopted a three-pronged strategy to ensure that everyone would graduate as planned; first, acting swiftly to move the curriculum online – achieving in two weeks the agility and flexibility they had been developing for two years.

Second, the university sought to act on the advice from public health authorities. Third, it developed creative approaches to supporting both staff and students.

'With the onset of the pandemic, work and life in general was a very scary place for many people, so we set up communities of practice. The primary consideration was, "nobody left behind",' says Professor Craig.

The College worked with parents and students edgy about the climbing infection rate in Australia in early March, encouraging them to 'keep the faith' because once borders were closed, there would be no quick way back.

In late May, the whole university returned to campus, with the College on track to deliver on its promise that no student would be left behind.

'At no point did we withdraw our placements and we were always committed to graduation and that commitment looks like it is going to be fulfilled,' Professor Craig says.

He says that while nobody wants a pandemic, if you are in the business of training the next generation of doctors, it makes sense to use any new challenge as a learning opportunity.

'It does present enormous opportunities for learning, not only in terms of the technical elements about personal protective equipment, but also about culture and people responding to adversity,' Professor Craig says. 'These are the important things that ultimately make for good doctors and clinicians.

'Our medical program students continued their Year 3 and 4 placements – that hasn't been the case across the state or the country. But we felt very strongly that if we are a publicly funded institution and we expect that the community in the future would be cared for by our graduates, those graduates should be trained to cope with every possibility. And that includes pandemics.

'There are probably about 20 things where we are going to be better and stronger than previously; for example, the partnerships we've had with our student members are probably even stronger than they have been.'

Equally, he says, the staff community has flourished throughout the pandemic.

'One of the challenges is that we are a very spread-out College but in a Zoom or Teams meeting, everyone is communicating whether your office is in the same corridor or in Nhulunbuy. (For example) the community of educators started with a relatively small group and then blossomed to include 70 staff who met three times a week for an hour – it's basically sharing innovations they had brought to their teaching.'

Professor Craig says the COVID-19 response reflected a broader Flinders University philosophy: people, culture, innovation, excellence and social vision.

'Everybody within the College has a sense that they are supported and that cared for,' he says. 'Culture is also critically important – a culture of diversity and inclusion; one that supports gender equity, supports the rights and voice of Aboriginal people and whereby people are treated positively irrespective of where they went to school and what their various family lineages might have looked like.

'Around excellence, we do aspire to produce Australia's most capable and engaged medical graduates. We want our staff inspired to support our students to graduate with the best possible degree, we want to do great research, and we want students to get a great education.

Professor Jonathan Craig

'And social vision – we expect our graduates, our young doctors to be trained to the best possible standards that they deliver the best care.'

The community theme is one that has directed Professor Craig's decision-making throughout his life. He is internationally celebrated for his work in paediatric nephrology and epidemiology – particularly in kidney disease in children and Indigenous communities.

'I chose paediatrics because if you are going to invest in something, why wouldn't you invest in kids?' he asks.

'There is potential to shape their entire trajectory and I wanted, very broadly, to be like the senior clinical role models I was profoundly impressed by.'

With his previous appointments at the Children's Hospital at Westmead and in the School of Public Health at Sydney University, as well as his position in the Flinders College of Medicine and Public Health, he's recently chosen to influence community outcomes through teams and team building. It's about the people, he says.

'This is a position that enables you to invest in a large number of people, both academic staff and students, who can make the sort of difference you as an individual could never have,' he says.

'I think that if you start off in a career in health it is all about the health of individuals and about communities – that's the predominant reason why we do what we do.'

Jigsaw pieces beginning to fit

Adelaide Medical School Interim Dean Professor Cherrie Galletly is finding the right places for the right pieces in her new role.

Professor Cherrie Galletly

As a psychiatrist who specialises in working with people with schizophrenia and other psychoses, and post-traumatic stress disorder (PTSD), the Interim Dean of Medicine at the University of Adelaide, Professor Cherrie Galletly, is accustomed to turning crises into a strategy.

Since graduating as a psychiatrist in Dunedin, New Zealand and moving to Adelaide, Professor Galletly has turned a 'knack' for helping people with some of the most complex mental illnesses into a stellar career, combining research into the neurosciences and clinical psychiatry, academia, private practice and parenthood.

She continues to be excited by the prospect of working with severely ill people, buoyed by their courage, and the opportunities to help them move from a 'pretty terrible situation to a pretty reasonable situation' with medication, individual support, and community and family rehabilitation.

There's also the prospect of a major leap forward in the understanding of schizophrenia and psychoses through imaging, brain networks and genetics.

'I feel that we are on the edge of a major paradigm shift or a breakthrough in the area of psychoses,' Professor Galletly says. 'It hasn't come yet – I'm hoping it comes in my lifetime.

'It's like all the bits of a jigsaw and they don't quite fit together and you feel like you are just missing some major part of it, or that you are looking at it the wrong way and one by one we'll tease out the different causes. It is an exciting time.'

Professor Galletly's new role as Interim Dean has required her to bring many pieces of her background and expertise into the 'jigsaw' that is academic leadership. She is enthusiastic about a position that allows her to work with 'lovely, highly intelligent, very motivated students'. But given the unprecedented challenges of the COVID-19 shutdown, it is a job that could have tested the mental health of a less well-equipped professional. Professor Galletly is also Chair of Psychiatry, a position supported by the University of Adelaide and Ramsay Health Care (SA), and Director of Mental Health Research and Training in the Northern Adelaide Local Health Network.

'In a response to the COVID-19 pandemic, Australian Government restrictions and in compliance with the University of Adelaide response, the Adelaide Medical School had to reinvent the wheel in five weeks to accommodate online teaching across all years of our medical program, finding a way for the small group, apprenticeship-style learning to work with Zoom and social distancing,' Professor Galletly says.

'People have learned how to do Zoom tutorials and online lectures – they've done all the things they've needed to do to get a medical program online in a very short time.

'The online teaching and the new methods of assessments we've developed – I think many of those will improve the MBBS. There has been a lot of innovation and change; there have been advantages.'

Final-year student placements will be fewer and longer – 12 weeks versus the traditional four to six weeks – and the graduates will have had different experiences but will be no less well-equipped, she says. Fifth-year students will be able to sit their barrier exams, including the Objective Structured Clinical Examination (OSCE) – even if it has to be done by Zoom.

'We did guarantee to our students that each year of students would progress to the next year [providing they satisfy the academic requirements of the program]; that there wouldn't be a year who would miss out and I'm very confident we'll achieve that,' Professor Galletly says.

'We've managed to adapt to meet the Australian Medical Council (AMC) requirements, and our final-year program adaptations have been approved by the AMC. This was an enormous accomplishment.'

She says having a six-year program model for school leavers – with students completing the pre-clinical teaching, skills and simulation before undertaking three full years of clinical placement – has given the Adelaide Medical School some breathing room in dealing with the COVID-19 pandemic.

Holding barrier exams in fifth year to allow the sixth-year students to focus on preparing for internships also ensures students will be well-equipped for the workplace – in everything from conflict in the workplace and bullying, ethics, and how to handle difficult situations to protecting their wellbeing.

Professor Galletly says the Faculty of Health and Medical Sciences under Executive Dean Professor, Benjamin Kile, is running on all cylinders, with a strong commitment to a collaborative teaching style.

The school's leading medical program continues to attract the brightest minds, and is expected to be further strengthened with the move to a new Bachelor of Medical Studies and Doctor of Medicine from 2022.

'We are coming out of this with all of our students having had a different experience, perhaps adapted, but still an excellent degree,' she says.

Light at the end of the tunnel?

JADE PISANIELLO
STUDENT NEWS:
ADELAIDE UNIVERSITY

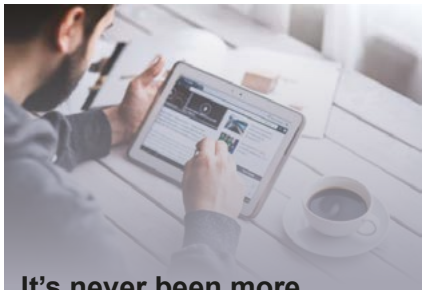
Throughout the six years of medical school, every student is told by their seniors that there is light at the end of the tunnel. All those nights and days spent in Barr Smith or the RAH library would eventually be rewarded with sixth year. If a picturesque city had a hospital, it wouldn't matter how far from South Australia that city might have been, you could bet that a sixth-year student from this state was 'completing' their Dean's Elective from the closest beach or bar.

Sadly, given the current global crisis, the vast majority of my cohort of soon-to-be-interns have had their overseas adventures cancelled. Initial disappointment was quickly outweighed by fears over the future of our placements and our ability to graduate, as placements were suspended and teaching paused. It was with a great sense of relief that all sixth years returned to placement recently, and this was only strengthened by an assurance from the AMC that we will be graduating on schedule, despite the disruptions. To the many University faculty staff members who assisted with this process and clinicians at these sites who welcomed students back with open arms – thank you! It could not have been an easy process.

Although our current placements are perhaps not akin to what many of us had planned during fifth-year SWOTVAC, which is of course the best reminder of how lucky we all our to be in this position at all.

Scrolling through my social media feed, I see none of my cohort sipping wine along the south coast of Italy, or swimming in the Bahamas. While I am saddened that we have missed out on these experiences, I am heartened every day when I see my peers on the ward or over Zoom tutorials. We have undertaken this journey together, for six years of highs and lows. We have watched each other grow and develop and we have supported each other through the fear and uncertainty of the past few months. This month, we have begun our applications to begin our medical careers as interns. Already our paths are beginning to diverge, but I look forward to what the future holds for every one of us.

Really, the joy of medical school is not confined to one single year, or a single overseas elective. Cliché though it may be, the joy is in the people you share it with. I've come to realise that all the days spent studying or on the wards were spent alongside friends that I know will remain friends for the rest of my life. This is not the year I had planned, and while I will look with some envy to those who came before and will come after, who will not have the disruption and disappointments we have had, it remains a privilege to be a member of this cohort. While next year will be challenging in its own way, we have proven we can rise to the occasion.



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

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To ensure you receive future 'bumper' (June and December) editions of medicSA, please provide your name, phone, postal address and preferred email address to: medicSA@amasa.org.au.

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

It's time to talk

LIAM RAMSEY
STUDENT NEWS:
FLINDERS UNIVERSITY

Parents talk about the birds and the bees with their kids, so why aren't doing that for our medical students? Medical schools have increasingly large curriculums to best train our fresh-faced doctors for the diversity within Australia. Nevertheless, gaps emerge when moulding these competent doctors, often in areas such as public health advocacy. We have improved the focus on some vulnerable groups in our population, but the discrimination that affects sex workers and gender-diverse people in our society persists in our medical education framework.

We certainly don't discuss sex workers' health and sexual violence and the medical implications. We don't learn about various sexual interactions and how people engage in sex. We don't delve into issues around sex and consent, or counselling around these issues. Sessions run by SHINE SA offer excellent information for students, but often those attending are not the ones that need to hear it. Not everyone will become sexual health physicians, but everyone will treat someone having sex.

Despite being trained in the anatomy, physiology and pathology of reproduction, our understanding of the complexities that surround sex and sex work are superficial.

We don't unpack the complex social and cultural factors that interplay with sex. We don't discuss that sex is really crucial to a person's holistic wellbeing, and that it comes in many different forms. We certainly don't discuss how it can be used as a profession and be empowering for people. We often discuss adverse consequences of sex such as sexually transmitted and blood-borne diseases, but that is where it ends.

Sex is very complex, and that's why sexual health is its own speciality. It is for this reason that it is important we teach students about the nuances of sexuality, gender and sex work. It is essential to safely educate and combat stigma which can progress to discrimination, which impairs utilisation of healthcare services for sex workers and gender diverse people in Australia.

It's vital that we engage in productive discussions about sex worker health at university. It identifies and challenges societal stigma and simultaneously educates us, to be able to provide the best care for all our patients. Sex work is still not decriminalised nationally and in SA it remains an offence under the *Summary Offences Act 1953*.

Engaging with health services can be increasingly distressing for sex workers, especially if they are met with judgement, even if unintentional. Stigmatised subgroups of people have worse health outcomes and higher levels of distress. Dr. Graham et al, and Women's Health West explore this further in their literature review *'The health status and health inequities of women, including transgender women, who sell sex services in Australia'*. It is implicit that this portion of our society requires our advocacy for their health needs, and therefore this must be part of our medical education. It is through broadening our learning that we become better doctors and service providers.

Awareness of intersectionality in our society, helps us to identify stigma and also highlight where there is a need for more education. We have a duty to provide safe and equitable healthcare to these groups of people. We have a moral responsibility to provide compassionate and decent care, and challenge pre-existing bias or stigma we have been taught to hold. I have witnessed many missed opportunities to appropriately care for patients who identify as LGBTQIA+ or work in sex work – opportunities to validate them, strengthen the community's opinion of us as a profession and provide personalised care.

Sexuality, gender identities, sexual orientation and their nuances may not seem as if they belong in medical education, but they do. They are relevant in not only reproductive health and mental health, but the overall holistic health of the individual. We need to see this emphasised in medical education and curriculum. It's imperative we do this, so we provide everyone the care they deserve.

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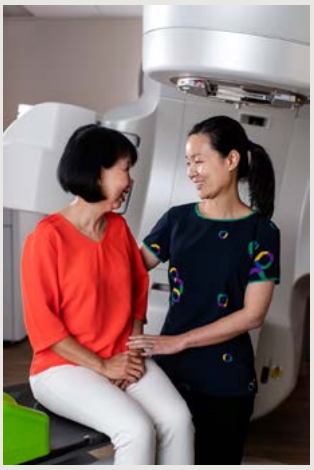

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Health-check your business

HOODSWEENEY
join the journey

As Australia brings COVID-19 cases under control, businesses, including practices and professionals, begin weighing the impacts on their lives and calculating how they can be more prepared for any devastating global pandemics in the future.

Hood Sweeney's Health Team, including Accounting & Business Advisory⁺, Finance# and Financial Planning* specialists, suggest it's a good time to run a health check on your business to ensure you're primed for a well-planned recovery.

'No one knows if or when another pandemic could occur, but we do know what we need to do now to recover, and how we can be better prepared for the future,' says Lisa Hickey, Health Team Leader and Representative of Hood Sweeney Accounting & Business Advisory (AFS Licence No. 485569).

Ms Hickey lists three focus areas as South Australia emerges from the period of isolation and shutdowns:

- projecting and budgeting – assess worst case, probable and best-case scenarios for the year ahead, particularly if you need to seek finance from banks at any stage
- cash flow – if you are having issues with cash flow, review options to defer payments, either tax payments or others, to ease the burden
- JobKeeper wage subsidies – are you correctly claiming for yourself and/ or your staff? The Australian Tax Office will be using audit procedures to ensure JobKeeper recipients qualify and that employers have appropriately identified employees.

Insurance is an area ripe for a health check. Health pandemics have not been priced into insurance premiums and while we haven't yet seen insurers alter terms and conditions of their insurance policies, it's possible that new contracts will include pandemic exclusion clauses.

'If you haven't already, it may be prudent to take advantage of the current, inclusive rules lest there are changes down the track,' says Mark Mullins, Associate Director and Representative* of Hood Sweeney Securities Pty Ltd (AFSL No. 220897).

He says life insurance policies typically recommend a lump-sum figure to mitigate the financial impact of death on a family. The calculations may consider:

- clearing debt to prevent lenders from defaulting, if surviving family members are unable to afford the repayments
- providing an ongoing income to a spouse who is caring for children or who doesn't have the same earning capacity as the deceased family member
- ensuring children can continue to attend the same school.

All insurers have some built-in default exclusions within their policies. Hood Sweeney Securities* acts as a broker when recommending insurers and its financial services license allows it to access most major Australian retail insurers.

If you or your business is due for a check-up, please email the Hood Sweeney Health Team at amasa@hoodsweeney.com.au or call 1300 764 200.

*Hood Sweeney Securities Pty Ltd,
AFSL No. 220897

⁺Hood Sweeney Accounting & Business Advisory,
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Dr Peter Subramaniam
Councillor

AMA(SA) Council Meeting June 2020

Due to the COVID-19 pandemic restriction and the AMA House fire, the June meeting was held in the 'new normal' of the Zoom virtual platform. Under the watch of the Chair, Vice-President Dr Michelle Atchison, an informal (but hard fought) competition for best virtual Zoom back-drop broke out.

Council was advised that Federal elections will be held electronically following a necessary constitutional change to be made at the upcoming Annual General Meeting, and had the opportunity to hear from one of the teams running for the elections, Dr Chris Zappala and his running mate, Dr Ines Rio.

The AMA(SA) has had a significant and important role during the early and escalation phases of the pandemic. The President thanked Council members who supported the AMA with technical advice and who responded with rapid decision-making during uncertain times – especially early in the pandemic lockdown. The President particularly acknowledged the input of the doctors in training and medical student representatives of Council in responding to the pandemic crises. Dr Moy observed that the federal and state healthcare systems responded as a single, unified entity, which was crucial to a successful response to the challenges of the pandemic.

The President updated the Council on progress made on e-prescriptions and the expedited process for assessing patients' driving licences when appropriate.

The AMA(SA) Culture and Bullying Summit was noted to have been well received, with proposed recommendations to be included in a report, now being drafted, seen as an important way forward. Discussions focused on developing constructive partnerships with other representative organisations to achieve the aims of the Summit.

CEO Dr Samantha Mead detailed the unfortunate level of damage sustained in the AMA House fire. All AMA artefacts have been professionally cleaned and have been able to be preserved.

Doctors in Training representative Dr Hannah Szewczyk advised Council about the impact the pandemic travel restrictions and border closures are expected to have on the resident doctor workforce in both country and metropolitan hospitals. Council was updated on the impact of COVID-19 on regional services and, in particular, the emergency department of the Port Lincoln hospital, which will need significant upgrades to meet post-COVID requirements.

Council was advised that current GP hospital contracts will expire in November but that contracts have been extended because of the pandemic.

New telehealth assessment to support non-urgent patients

SA Ambulance service is strengthening its management of Triple Zero calls, using experienced paramedics to provide low acuity callers with clinical assessment.

The new Clinical Telephone Assessment service will initially focus on a defined cohort of low acuity patients.

The management of urgent Triple Zero calls will not change and urgent cases will continue to receive an emergency ambulance response.

However, callers with low acuity conditions may be transferred to a specialised paramedic telehealth clinician, who will conduct a detailed clinical assessment and recommend the most appropriate care for the caller.

Options for care may include:

- ambulance transport to hospital – either urgent or non-urgent
- referral to the patient's GP, GP Locum Service or another primary health service
- referral or ambulance transport to a Priority Care Centre
- home-based care.

Why is this change being made?

SAAS receives hundreds of Triple Zero calls every day, with many not requiring an emergency response. However, non-urgent patients often wait longer for an ambulance and are also most likely to be delayed on hospital ramps.

In addition, a hospital emergency department is not always the most appropriate place for people with less serious conditions.

SA Ambulance's Clinical Hub Operations Manager Kate Clarke with Clinical Telephone Assessment team leaders Sarah Evreniadis and Nick Marks

Clinical telephone assessment will:

- streamline their access to the most appropriate care
- support the utilisation of non-emergency pathways of care
- leave more ambulances, crews and other emergency resources available for more urgent patients.

For more information on Clinical Telephone Assessment, visit http://www.saambulance.com.au/ProductsServices/CTAClinicalTelephoneAssessment.aspx

Polio's permanent reminders

The late effects of a disease that ravaged Australia are still felt, but little understood, write Dr Nigel Quadros and Michael Jackson.

School-aged boys await their Salk polio vaccinations

Polio is no longer a challenge in Australia, yet its ageing survivors have a different perception of the disease than do others untouched by the disease. Polio survivors report a range of symptoms that are related to late effects of polio (LEoP) in addition to secondary, age-related, health comorbidities.

The significant health barriers faced by ageing Australian polio survivors are the result of LEoP symptoms and those of its subset post-polio syndrome (PPS) – and, most importantly, a health care system in which health professionals do not recognise the conditions and their needs.

LEoP manifests decades after an initial polio virus infection, in some who developed acute and residual paralysis, as well as in some who had the non-paralytic form of poliomyelitis (1).

The most common symptoms, variable both within and between individuals, include (2):

- new and worsening weakness
- central and peripheral fatigue
- myalgia
- sleep difficulty
- cold intolerance.

Australia was declared polio free by the World Health Organization in 2000; hence, many younger health professionals have little or no experience in management of acute poliomyelitis and its long-term effects. This creates an education void between the ageing polio survivors who are well educated on their condition, and the health professionals with little or no experience in managing their impairments.

Yet many Australian medical professionals, whether aware of it or not, have likely treated a local polio survivor. The community antipathy experienced by polio survivors during childhood is not forgotten and has consequences: some are reluctant to share their history of polio, others deny that their childhood condition is returning to challenge their function again, and others do not realise they had polio at all.

The barriers faced by polio survivors when interacting with the medical profession include their doctors' lack of experience of their condition, the attribution of their symptoms to other causes, or in some cases, a denial of the existence of LEoP.

In early 2020, Polio Australia conducted a nationwide survey of polio survivors. Of the 734 respondents, 133 were South Australian. Among the SA cohort:

- 69% of those who experienced LEoP had problems when discussing health care needs with their doctors
- 81% respondents were aged 70-89 years
- 52% were male
- 67 % live in a metropolitan area
- 68% report one or no other chronic health condition
- 32% would like to join a support group.

Three in five respondents felt their general practitioner (GP) had sufficient knowledge of LEoP, while only one in four felt that the GP was willing to learn about it. Almost 50% of those surveyed expressed low confidence in the ability of new GPs, new specialists including anaesthetists, and new allied health professionals to manage LEoP.

Polio Australia has provided free professional education workshops to more than 1,300 health professionals across Australia to reduce these education barriers.

GP'S MANAGEMENT OF SURVIVORS

Elderly polio survivors present with a constellation of symptoms due to impairment caused by LEoP as well as secondary health conditions; the delineation between the two is difficult.

Addressing major symptoms of LEoP

The most common symptoms of LEoP are fatigue, increased or new muscle weakness, muscle and joint pain, and new difficulties in activity of daily living (3).

Fatigue has multiple aetiologies and prior to being attributed mainly to LEoP, other medical conditions necessary to exclude include hypothyroidism, anaemia, cardiac disease, diabetes mellitus, chronic infections, renal and liver disease, sleep apnoea, depression, anxiety and stress (4).

Weakness in LEoP is mainly attributed to motor neuron dysfunction, but other causes of new weakness must be excluded: inflammatory demyelinating disease, multiple sclerosis, Parkinson's disease, cerebrovascular disease, myasthenia gravis, amyotrophic lateral sclerosis etc. Muscle weakness is assymetrical in pattern, and involves polio affected and unaffected muscles. Clinical signs include fasciculations, muscle cramps, and atrophy. Biochemically elevated serum creatinine kinase may be noted (5).

Pain manifests as muscle pain – described as deep and acheing or superficial and burning – and overuse pain caused by improper body biomechanics leading to soft tissue, muscle, tendon, ligaments and bursa injuries. Assessment involves other conditions that could be producing pain such as degenerative disc and joint disease, radiculopathies, spondylolisthesis, scoliosis, spinal canal stenosis, fibromyalgia etc. (6).

GP knowledge and understanding

Exercise - general recommendations are low resistance, high repetitions and frequent rest periods of sufficient duration to allow recovery from muscle fatigue (7).

Falls - ageing polio survivors are at an increased risk of falls compared to the general population due to problems maintaining balance, weakness in knee extension and a fear of falling (8). Osteopenia and osteoporosis are common in affected limbs, thereby increasing the risk of fragility fractures (9).

Medications - commonly prescribed medications such as statins, beta blockers, CNS depressants,

benzodiazepines, local anaesthetics and muscle relaxants may worsen fatigue and weakness; their usage requires careful evaluation of risk versus benefits. In some instances, dose reduction is necessary (10).

Anaesthesia and surgery - special anesthetic considerations are needed when treating patients with history of poliomyelitis due to increased likelihood of altered respiratory function, chronic pain syndromes, cold intolerance, aspiration, and altered sensitivity to anesthetic agents (induction agents, inhaled anesthetics, neuromuscular agents, opioids and regional and general anaesthesia medications). A discussion with the anesthesiologist is advisable to provide safe care (11).

In 2020 the RACGP endorsed a LEoP information brochure, and more information is available at www.poliohealth.org.au. A GP education module on LEoP is in development, and a LEoP pathway has been requested of HealthPathways South Australia.

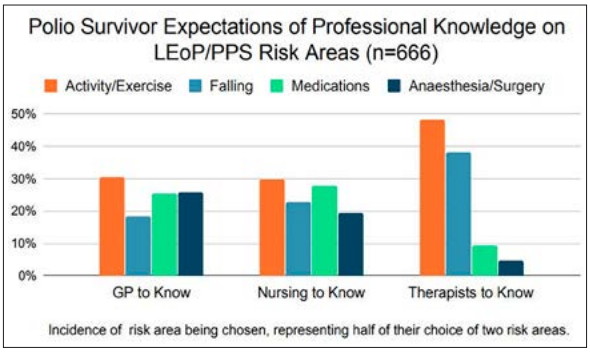
Establishing a GP management plan

Key components of a plan for GP care would include:

- Discussing with the patient -
  - ➢ healthy lifestyle with exercise, weight loss and stress management
  - ➢ fatigue and activity activity strategies
  - ➢ effective pain management
  - ➢ lower falls risk
  - ➢ treatment options for secondary medical/surgical conditions including anaesthetic use
- Referring to skilled allied health professionals, rehabilitation medicine physicians, neurologists, respiratory physicians as individual patients need
- Directing to PolioSA (www.poliosa.org.au) for local support, and to Polio Australia (www.polioaustralia.org.au) for polio resources.

A thorough understanding of LEoP is necessary to treat ageing polio survivors. The GP plays a pivotal role in managing these patients and can promote their health and wellbeing by being aware of the condition and seeking advice from skilled health professionals with a special interest in this condition.

The reference list is available at: https://www.poliohealth.org.au/ama-sarefs/



LEoP knowledge that polio survivors expect of several health professions (2020 Polio Australia Survey)

Dr Nigel Quadros is Senior Consultant Rehabilitation Medicine at the Queen Elizabeth Hospital and Hampstead Rehabilitation Centre, Michael Jackson is Clinical Health Educator for Polio Australia. Co-author Brett Howard (now deceased) was President of PolioSA and Vice-President of Polio Australia.

Norman Waterhouse

Preparing for the 'new normal'

Adelaide law firm Norman Waterhouse has recommendations for the doctors who face changes to their work practices during the pandemic.

Lincoln Smith

Sathish Dasan

Ganesh Krishnan

As the Federal and State Governments ease restrictions in relation to COVID-19, it is important for employers to consider how they are transitioning from the COVID-19 pandemic and adjusting to the 'new normal', as well as being prepared if a second wave of COVID-19 occurs.

There are areas employers should be aware of as they adjust and the dust settles, as well as lessons learned from how businesses have managed during these unpredictable times.

FLEXIBLE WORKING ARRANGEMENTS

Many employees have, either by choice or at the direction of their employer, worked from home during the COVID-19 pandemic. It is likely that many employees prefer the flexibility of working from home and employers may receive more requests for flexible working arrangements.

Section 65 of the *Fair Work Act 2009* (Cth) enables certain employees to request a change to their working arrangements, depending on whether certain circumstances apply to them. For example, a request from an employee who is the parent of a school-aged or younger child, or who is 55 years or older, may only be refused on 'reasonable business grounds', which include that new working arrangements would be too costly, the changes may result in a significant loss of efficiency or productivity, or customer service would suffer.

If employers consider that it is appropriate for their employees to continue working from home, the arrangement should be outlined in a written flexible working agreement. To ensure uniformity, this agreement should align with your organisation's flexible working arrangement policy, which explains its position on the period of the flexible arrangement and any review, employees' duties and hours of work, work health and safety guidelines, and requirements for maintaining confidentiality of information.

REINVIGORATING WORKPLACE CULTURE

Due to the rapid onset of restrictions, it may be that the time away from the office allowed any workplace tensions among employees to simmer or remain unresolved. When employees are returning to work to the employer's premises, it is an ideal time to start fresh with employees and implement teambuilding exercises and workplace training, such as conflict resolution and appropriate conduct training.

There are also socialising factors to consider. As employees return to workplaces, and restaurants and pubs reopen, there is a natural desire to socialise, including in workplace functions. Employers should have appropriate drug and alcohol policies in place and ensure that employees are aware of the behaviour expected of them 'post COVID-19', such as maintaining social distancing and practicing good hygiene in accordance with government guidelines.

Employers should also be pro-active and understand that improving workplace culture starts at the executive level. They should understand that some employees may struggle with returning to the workplace, especially in a full-time capacity. It's advisable to consult

with employees before their return, including discussion of:

- safety measures and procedures now in place, such as social distancing in the office, regular cleaning of communal areas and individual workplaces, limiting the number of people at in-person meetings, and encouraging video and teleconference meetings when possible
- encouraging employees to use their sick leave and not come to the office if they have cold or flu symptoms (which are similar to COVID-19 symptoms)
- what will happen if an employee contracts COVID-19 or is found to have been in contact with someone who has COVID-19
- what an employee should do if they are a high-risk person or lives with someone who is a high-risk person (including if they are immunocompromised), and whether they will be able to continue working from home
- making services such as Employee Access Programs (EAP) or other (internal or external) counselling available to staff.

ORGANISATIONAL RESTRUCTURE

Many businesses will have had to review their operations, financial streams and sustainability, especially in consideration of access to JobKeeper payments.

From such reviews, organisations should consider whether they can increase business efficiencies through changing IT platforms, processes and staff members' duties. A restructure may be advisable; this could include an examination of employees' employment contracts and position descriptions to determine whether certain duties are no longer needed, if they should be outsourced, or whether certain roles and duties can be merged. If an employer undertakes a restructure, it is imperative that they consult with affected employees.

LESSONS LEARNED

COVID-19 has affected all industries across Australia. But the reality is that a crisis or unexpected disaster can affect any business at any time. For example, an unexpected event such as a fire, an IT attack, the death of a senior employee – or even a second wave of COVID-19 – will have sudden adverse impacts, similar to the impacts of the pandemic.

Business continuity preparation is imperative if a business is going to effectively manage any of these situations and emerge ready perform as its customers need and expect. To ensure you have a robust internal business continuity plan:

- review your IT systems and ensure your company's information is protected
- review employment contracts to ensure they allow for flexibility and that duties are appropriate and necessary
- review leave balances
- review or implement an emergency plan
- ensure human resources policies and guidelines are robust and flexible
- if needed, introduce training that will improve your workplace culture.

For more information please contact Sathish Dasan on 8210 1253, Lincoln Smith on 8210 1203 or Ganesh Krishnan on 8217 1395, or email Lincoln on lsmith@normans.com.au.

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⁺Lisa Hickey, Heang Lay and Trien Ly are Representatives of Hood Sweeney Accounting & Business Advisory AFSL 485569

*Adrian Zoppa and Mark Mullins are Representatives of Hood Sweeney Securities Pty Ltd AFSL No. 220897

Connecting to Country

South Australian programs are reinforcing the benefits of relationships with Country.

For thousands of years, Aboriginal people and communities have understood, experienced and celebrated a spiritual connection with their ancestral lands and waters. Aboriginal people see themselves as belonging to Country and every aspect of themselves and their life as holistically interconnected with Country. This connection is distinctly personal; Country is regarded like a family member. The relationship with Country is interdependent, reciprocal and sustained through cultural knowledge.

Connection and re-connection to Country are significant determinants of health and wellbeing for Aboriginal people; they form part of Aboriginal peoples' sense of belonging and self-determination.

Building on this long-standing traditional knowledge and evidence base, an increasing body of western evidence is demonstrating that connection to family and community, land and sea, and culture and identity is integral to Aboriginal health and wellbeing. Numerous studies also confirm the benefits that arise from Aboriginal people's reciprocal relationship with Country through Connection to Country initiatives. Connection to Country centres on the relationships between Aboriginal people and their Country, and includes activities that reinforce and support relationships with physical, cultural, social, economic and spiritual environments.

In South Australia, there are many programs and initiatives that promote the significant mental, physical and social health and wellbeing benefits of Connection to Country.

In March 2018, the South East Junction (Mental Health Activity and Resource Centre Inc., in Mount Gambier, Millicent and Penola) and Natural Resources South East started 'Walking the South East Seasons with Nature in Mind. The program – led by Aboriginal Elders – provides a unique perspective of First Nations culture and connections to the region.

Framed around the South East Aboriginal Focus Group's Weaving the South East Seasons Calendar, the program enables participants to contribute to environmental sustainability and experience the benefits of connecting to Country. This is modelled on a successful program run with headspace Mount Gambier in 2017.

In July 2019 a participant group set off for Kalangadoo to view the Yuki scar tree – a Yuki is a traditional style bark canoe carved from a red gum. In 2010 Elder Major Sumner (Moogy) and Uncle Cyril Trevorrow had spent six hours in a cherry picker carving the canoe from the bark; the finished Yuki measured four metres and was cured on a smoky fire. Three months later it was floated at Lake Leake near Mount Gambier and later in 2010 it was floated as part of the National Water Craft Conference on Darling Harbour, Sydney.

The July trip also incorporated a 3 km walk around the perimeter of the Mt Burr Rock Shelter Forest Reserve, which ended with a cultural session with Aboriginal Elder and South East Aboriginal Focus Group member, Doug Nicholls. The cultural session included a smoking ceremony, didgeridoo playing and discussion about the rock shelter site. A visit and song from a flock of about 15 yellow tail black cockatoos finished the outing. 'Being out on-Country, immersed in the environment with like-minded people is great for anyone's mental health!' says David New, Aboriginal Engagement Officer, Natural Resources South East.

Moogy's Yuki Scar Tree at Kalangadoo

Mr New says programs such as the 'Walking the South East Seasons with Nature in Mind' provide important opportunities for connecting to Country and learning about the significant relationship between Aboriginal people and Country.

He refers to the South Australian Government's 'Joint Statement of Action: Connection to Country', which states that Connection to Country is underpinned by leadership, healing, learning, promoting places of cultural significance, sovereignty, promotion of traditional languages and culture'.

'Previous participants have commented that the program provides opportunities for being in nature, that make you feel happier, more peaceful, better for being involved,' Mr New says. 'Other reports suggest that the experience stimulates energy, creativity and learning and provides opportunities to make new friends and be surrounded by other likeminded people.'

Nel Jans, Coordinator at the South East Junction, says some participants have since engaged with other Junction Programs and Connection to Country walks. Others have commented that the experience inspired them to try non-guided Connection to Country experiences.

'This has been particularly important amid the recent COVID-19 situation,' she says. 'With many community activities and facilities on hold, some program participants have done their own walks. This demonstrates a sense of resilience and self-empowerment for protecting personal wellbeing, likely strengthened by what was learnt through the program.'

50 things every doctor should know

In 2018, Michael Sorkin, an American architect and designer, wrote *250 Things An Architect Should Know.* (https://www.readingdesign.org/250-things) To a non-architect the list is whimsical and inspiring. There are items on his list that are technical and others that are philosophical, but the inherent message is that there is more to a profession and life than is taught in textbooks.

Inspired by *250 Things*, presented here are *50 Things Every Doctor Should Know*. You may have your own 'things' to add!

Dr Troye Wallett is a GP and does not presume to know what doctors should know. He presents this list, in a spirit of amusement and whimsy, for consideration and pondering. He loves to hear from people so if there are any items you think need to be on the list, please email him at troye@troyewallett.com. Let's collaborate to make the list '250 Things', like the architects.

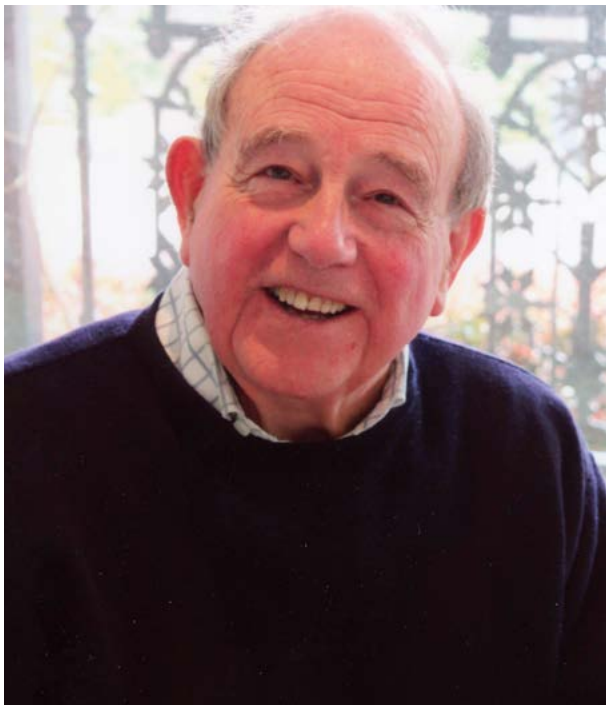
1. The fundamentals of chemistry.
2. The fundamentals of physics.
3. Basic statistics.
4. The scientific method.
5. The Dunning Kruger Effect.
6. **What to refuse to do, even for the money.**
7. The importance of 'measure twice, cut once'.
8. How to ask for and accept help.
9. Who to go to in an emergency.
10. Whose shoulder to cry on.
11. When to say, 'I don't know'.
12. When to stand up in the face of criticism.
13. **When to stand up for your patient and when to argue with them.**
14. How to celebrate small victories.
15. Conversation starters for three-year-olds.
16. How to make a duck from a glove.
17. What makes babies laugh.
18. The power of therapeutic touch.
19. The placebo effect and how to use it effectively and ethically.

20. Germ theory and the importance of hand washing (obviously!).
21. Gauging and managing risk.
22. When to walk, and when to run.
23. How to bring calm to a stressful situation.
24. How to recognise and treat a pneumothorax on the side of the road with no medical equipment at hand.
25. How to stop a bleed (especially epistaxis).
26. CPR.
27. Safely dealing with sharps.
28. QWERTY.
29. The power of compound interest.
30. The power of compounding their interests.
31. How to cultivate a growth mindset.
32. Their own blood pressure and fasting glucose.
33. Where to obtain a healthy snack.
34. How to cook a healthy meal in less than 15 minutes.
35. The allergy season in their city or town.
36. Why patients come to see them.
37. Why patients really come to see them.
38. **That a patient knows more about themselves than their doctor does.**
39. A deep understanding of fear and how it deafens, blinds and drives people.
40. How to be a gracious team member.
41. The preferred warm drink of colleagues.
42. The difference between sympathy and empathy.
43. How to give and receive constructive feedback.
44. How to deliver a 20-minute teaching session with no notice.
45. How to say 'no'.
46. When to say 'yes'.
47. How to give.
48. How to receive.
49. What their mood enhancers are.
50. The realisation that their own life comes first.

The heart of the matter

Dr Peter Stuart Hetzel AM KStLJ
MD, BS MSc, FRCP, FRACP, FCSANZ

1924 – 2020



Dr Peter Hetzel

'A true gentleman'

Eminent cardiologist Peter Hetzel was instrumental in establishing cardiopulmonary bypass (open heart) surgery at the Royal Adelaide Hospital (RAH) from 1960.

The younger son of Kenneth and Elinor Hetzel, Peter was born in London on 8 November 1924, while his father was on a scholarship from his medical practice in Adelaide. The family returned to Adelaide in 1925. Peter and his brother Basil attended school at Kings College (now part of Pembroke) and later St Peter's College. He began his medical studies at the Adelaide Medical School in 1943, graduating in 1948.

After an intern year at the RAH, Peter won a surgical research position at the Institute of Medical and Veterinary Science (IMVS), investigating fluid balance problems and potassium loss and using Dextran as a plasma substitute, and earned his MD. He then joined the Mayo Clinic in Rochester, Minnesota, working there for five years as a clinical researcher. He was involved in the development of the cardiopulmonary bypass pump, techniques for measuring cardiac output, and intracardiac measures and shunts. Accurate diagnosis of intracardiac defects and physiology was crucial for the success of intracardiac surgery and the development of these techniques was an exciting time.

At the Mayo Clinic, Peter was part of a team that began experimental work in cardiopulmonary bypass in 1954 – using dogs – and results were published in 1955. In 1956, they began performing cardiopulmonary bypass using a modifier pump. During his period at Rochester, there were two places in the world where open heart surgery was being conducted, and they were less than 150 km apart.

In late 1956 Peter took up a position as a research registrar at the Brompton Hospital in London, where he worked with Paul Woods, and continued his research in cardiac output and intracardial pressures. He returned with his family to Adelaide in 1958 and took a position as part-time registrar at the RAH while also performing clinical work in his father's rooms on North Terrace. Peter also had an honorary visiting appointment to the Women's and Children's Hospital to help manage children with congenital heart disease.

After much discussion, particularly with Dr Darcy Sutherland in 1959, Peter wrote a submission to South Australia's Department of Health on how cardiac surgery could be further developed in Adelaide. State Cabinet approved the proposal within a month.

In January 1960 Peter was appointed Director of the Cardiopulmonary Investigation Unit (CPIU) at the RAH. The CPIU had four components:

- cardiac investigation (led by Peter)
- respiratory investigation (led by Dr Michael Drew)
- cardiac perfusion (led by Dr John Waddy)
- medical electronics (led by Mr Neville Martin).

These teams supported Dr Sutherland in cardiothoracic surgery and the initial open heart surgery in 1960. Valve replacement followed in 1963. Cardiac surgery was very successful and went on to great strengths. In December 1962 an article was printed in the *Medical Journal of Australia* entitled 'Initial experiences with open heart surgery' by Dr Sutherland, Dr Hetzel, Dr Waddy and anaesthetist Dr Pauline Daniels. By the mid-1960s 25 per cent of all Australia's cardiac surgery was performed at the RAH.

Peter continued as a clinician, teacher and researcher for many years. He was very supportive of younger cardiologists and assisted in the introduction of new techniques of investigation and intervention. He retired as Director of the CPIU in 1985 and returned as a visiting medical officer on five sessions until 1989, continued in private clinical practice until 2002, and provided medico-legal assessments until 2018.

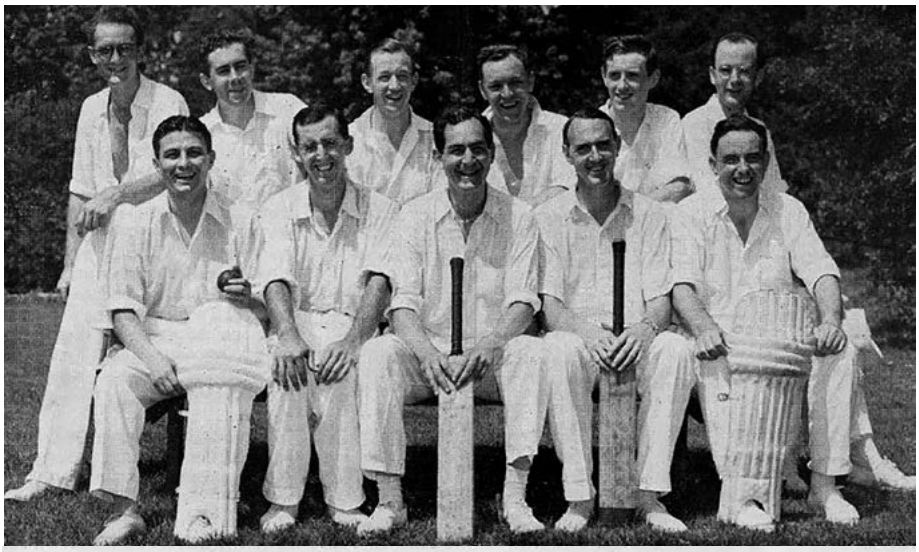
Peter was a dedicated family man. He married Margaret (nee Mackie) in 1954 and they had four daughters – Diana, Philippa, Penelope and Catriona. He was keenly interested in staff affairs; as president of the South Australian Salaried Medical Officers Association (SASMOA) he helped initiate superannuation for the visiting medical staff.

Additionally, Peter was an active parishioner of Scots Church on North Terrace, chairman of the Board of Presbyterian Girls' College (now Seymour College) and a great supporter of the Uniting Church. He was chairman of the RAH Heritage and History Committee for 12 years from 2006.

Peter was a true gentleman. He was of a very even temperament, always pleasant and supportive of his colleagues, students, and the nursing and ancillary staff. He was a pleasure to work for and with. He is missed by many.

Cardiologist Dr Leo Mahar was a colleague and friend of Dr Hetzel.

An oral history that records an extended and fascinating interview with Dr Peter Hetzel in 2006 (OH 172/35) is available from the State Library of South Australia at https://archival.collections.slsa.sa.gov.au/oh/OH172_35.pdf. The information in the oral history helped prepare this obituary.



Five Countries Represented on Team

MAYO CRICKET TEAM members—all Foundation Fellows—come from all parts of the British Commonwealth. In the front row, from left to right: Ed Hirst and Bill Dunlop, Sydney, Australia; Captain Alex Walt, Capetown, South Africa; Tim Furber, Sydney, Australia; Peter Hetzel, Adelaide, Australia. Back row: Nick Greville, London, England; Jeremy Swan, Sligo, Ireland; Pat Forrest, Dundee, Scotland; Matt Divertie, Paisley, Scotland; Alistair Gillies, Edinburgh, Scotland, and Ross Mitchell, Dundee, Scotland. The high percentage of Aussies on this representative team is not coincidental, by the way; the men from Down Under are currently doing well in all international sports competition. Above: Tired, sunburned, pleased with the match are Dunlop, Divertie, Gillies and Greville.

Dr Hetzel (seated far right) enjoyed cricket while in Rochester.

Renaissance man

Dr Andrew Stanislaus Czechowicz
M.BS, FRANZCP, FRACMA, FACRM, FAFRM (RACP),
Grad Dip Health Admin.

1940 – 2020

Dr Andy Czechowicz at a conference at Adelaide Oval

'An eternal student'

Andrew Stanislaus Czechowicz, universally known as Andy, was born during the Second World War, at Vilnius, then a Polish city where his father Gustaw practised medicine. Towards the end of the war the family was forced to flee the impending occupation by the Soviet army, and Gustaw took his wife Wiktoria, his three sons, Andrew, Leon, and Romuald, and Wiktoria's parents west across Europe. At the end of the war they found themselves in a refugee camp in the American zone in Germany. In 1950 they were among the great wave of 182,159 displaced Eastern Europeans sponsored by the International Refugee Organisation (IRO) who arrived in Australia between 1945 and 1954. They were placed at the Willaston refugee hostel and then settled at Gawler.

Gustaw had to work at a variety of basic jobs to support his family and never had the opportunity to practise medicine in Australia. He did, however, found a medical dynasty. Two of his sons and two of his grandsons practised medicine, and a great-granddaughter is now studying medicine at Flinders University.

Andy's Australian education began at the Good Samaritan Convent School at Gawler. Starting with no English, he won the English prize in grade 7 and began his high school education at Christian Brothers College in Adelaide on a scholarship. He again excelled and gained a Commonwealth Scholarship to fund his medical education.

Andy was an eternal student. This term is often applied in a pejorative sense to describe someone who protracts formal education rather than graduating and facing the real world. I use it in a positive way as 'living is learning'. Andy had numerous interests and insatiable curiosity. When faced with a new subject or issue he tried to find out everything that was known about it. He applied this approach to every aspect of his professional career.

Although Andy had many interests, there was never any doubt he would specialise in psychiatry. Family legend has it that he proclaimed this as a small boy. He trained in psychiatry at the Glenside Hospital at a time when a dramatic transformation was taking place in the practice of psychiatry and provision of mental health care in South Australia, and nationally as the Australasian Association of Psychiatrists (AAP), evolved into the ANZCP, now the RANZCP.

The transformation in South Australia was triggered by the arrival of Professor William 'Bill' Cramond in 1963. He dragged psychiatry into the 20th century. On his graduation Andy became a leader in the application of the new methods and was continually active in the education program for trainees in South Australia.

He held senior positions in health administration from the beginning of his career. In 1977 he was appointed as the Superintendent of Hillcrest Hospital, and in 1980 the Superintendent and CEO of the Glenside Hospital.

Throughout his career he was actively involved in formal professional affairs. As a student, he joined the BMA (SA Branch), which merged with the AMA in 1962. He remained an active member and was granted Life Membership of the AMA in 2017. Similarly, he was active in the affairs of the RANZCP.

He was always involved in psychiatric education and training, and in addition to active involvement with his College had academic status with the University of Adelaide and Flinders University.

Whatever his administrative role, he always remained clinically active. His interest in psychiatric rehabilitation led to him becoming a Fellow with the new College of Rehabilitation Medicine in 1981, and his interest in herbal remedies led to his co-authorship of the book *Herbal Remedies: Harmful and Beneficial Effects* in 1989.

Andy was immensely proud of his Polish heritage and served on many committees, usually as Chairman. As a member of the Polish community he was the President of the Committee that established the international SA Violin Competition, which ran for a number of years. He was awarded the Centenary Medal 'to recognise people who made a contribution to Australian society or government' on the nomination of the Polish Community.

Andy was always sought out by Polish Australian patients, not only because of his knowledge of the Polish language but because he understood the culture and the impact of the migration experience on their lives. He had a great

interest in Aboriginal mental health; he was the visiting psychiatrist to the Anangu Lands 1976–1979 and continued to care for Aboriginal patients throughout his career.

In recent years he had a great interest in adult ADHD. I had many useful and interesting conversations with him because some of the troublesome changes in personality and behaviour found in dementia also suggested parallels with ADHD.

Andy and his life partner, Maryla, were great travellers for business and pleasure and had friends around the world. They went to France to attend the wedding of a young woman doctor who had lived with them as an exchange student. She kept close contact with them for the rest of Andy's life. On their travels Andy took hundreds if not thousands of photographs with ever-more expensive cameras.

Andy was a proud and loving father and grandfather and enjoyed interacting with children. He was Uncle Andy to our daughters and many other children of relatives and close friends, as is the custom with Eastern Europeans and Australian Aboriginal people. He had a way with children. Camping on Hindmarsh Island they would discover dragon bones which Andy would describe in great seemingly scientific detail, until one of the children would turn to me and ask, 'Uncle Andy is being facetious isn't he?'.

His battle with oesophageal cancer took about four years. Maryla and his children - Gus, Lydia, and Sophie provided loving and exemplary palliative care. I called them 'Team Czechowicz' and was proud to be an associate member.

He died on Anzac Day, five days short of his 80th birthday. One of his great interests had been military history, and if he had gone down a different path, it would have been as a member of the Royal Australian Air Force. He died surrounded by his family and friends to the sound of *The Last Post*, which was being broadcast as he took his last breath.

Andy was a public servant for all his professional life. The sobriquet 'Renaissance man' was first applied to another famous Pole, Nicolaus Copernicus. Andy, like the astronomer, was a man of many parts.

Dr Czechowicz's fellow graduate and friend Dr Ludomyr Mykyta

Dr Czechowicz with Dr Ludomyr Mykyta in 2015 at the 50th anniversary celebration of their medical school graduation, and being honoured as a 50-year member of the AMA(SA) by then-President A/Prof William Tam in 2017

NOTICES

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

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

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

For convenience, referrals may be faxed to 8373 3853 or emailed to admin@hamiltonhouse.com.au.

For all appointments phone his friendly staff at Hamilton House 8272 6666.

www.hamiltonhouse.com.au

DR ROBERT J HALL, neurologist advises that he continues to perform electromyography (EMG) and nerve conduction studies at Adelaide Neurophysiology, Memorial Medical Centre, 1 Kermode St, North Adelaide. Phone 8239 1933, fax 8267 6672.

ROOMS FOR SALE OR LEASE

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TEMPORARY OFFICES FOR AMA(SA)

Please note that due to the fire that caused extensive damage to AMA House in North Adelaide on 6 May, AMA(SA) staff are now working from temporary premises in Dulwich.
If you wish to visit our office, please come to Level 1, 175 Fullarton Road, Dulwich.
Our phone numbers and email addresses remain the same. Our postal address remains PO Box 134, North Adelaide SA, 5006.
Email: admin@amasa.org.au or membership@amasa.org.au
Phone: 8361 0100

WE'RE HERE FOR YOU

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

STAY CONNECTED

The AMA(SA) is working closely with SA Health and other organisations to communicate the latest information to doctors and health practitioners across South Australia, and to ensure that emerging concerns are addressed.
If you have issues or queries about your membership, please email Rebecca at membership@amasa.org.au or phone 8361 0108.

AMA(SA) ANNUAL GENERAL MEETING AND MAY COUNCIL MEETING

Due to the pandemic, the Annual General Meeting (AGM) of the AMA(SA) was not held at AMA House as previously scheduled on 7 May 2020. The Board of AMA(SA) decided that an online format was not suitable for an AGM, during which all participating members must be able to provide questions and comments and have their involvement recorded. The postponement was in line with the South Australian Government's Consumer and Business Services advice.
We will inform members of the revised date as soon as possible. Please contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au if you have any questions.

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

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

GALA DINNER AND AMA(SA) ANNUAL AWARDS

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

Due to COVID-19, the 2020 Gala Dinner was cancelled and the awards will not be presented this year.

DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

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

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

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.

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

HELPFUL HINTS

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

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

To access your tax invoice:

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

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

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join the journey

MEMBER BENEFITS FROM HOOD SWEENEY

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

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AMA
SOUTH AUSTRALIA

FOR YOU, YOUR COLLEAGUES AND ALL SOUTH AUSTRALIANS

WE ARE STRONGER IF YOU ARE WITH US
WE ARE LOUDER IF YOU SPEAK THROUGH US
OUR INFLUENCE IS GREATER WHEN MORE OF YOU ARE BEHIND US

The AMA(SA) is proud of its long and proven history of supporting South Australia's doctors, and as a trusted advocate for the medical profession and the health of all South Australians.

Our value has never been more evident than in fighting COVID-19, when we've been pivotal in:

- Contributing to plans to stop the spread of COVID-19
- Introducing telehealth MBS and electronic prescribing
- Providing financial and mental health support for doctors
- Advocating for adequate PPE
- Supporting Doctors in Training and medical students.

DECISIONS ARE MADE BY THOSE WHO SHOW UP. SUPPORT THE ORGANISATION THAT SUPPORTS YOU.

JOIN NOW!

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