

# medicSA

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION (SOUTH AUSTRALIA) INC.



## Good news for mums and bubs in WCH move

**Mandatory reporting • Thai cave diving hero: 3 generations of medicos  
Maternity services • SA eating disorder services • A vision for health?  
Medical education • Working to eliminate nuclear threat • Life stories**



Volume 31 Number 6  
December 2018



## Committed to Referrer Education

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### Education Event - GP Referred MRI

Wednesday 21 November 2018 at the Adelaide Pavilion

This event will focus on the role of MRI imaging in diagnosing conditions pertaining to the brain, spine and musculoskeletal system. Additionally, it will provide a basic understanding of MRI physics and associated safety protocols.

#### Speakers

##### Dr James Harding – Radiologist

Dr Harding is a diagnostic and interventional radiologist with speciality interest in Nuclear Medicine, Sports Medicine Imaging and Imaging Guided Procedures.

Dr Harding is currently the Clinic Director at our Calvary Wakefield Hospital clinic and former Supervising Principal Radiologist at our Noarlunga Hospital clinic.

##### Dr Shabeer Hassam, Radiologist

Dr Hassam takes a special interest in CT and MRI, CT and Ultrasound Guided Procedures, Neuroradiology and Head and Neck Imaging.

Dr Hassam completed specialist radiology training at The Queen Elizabeth Hospital, Flinders Medical Centre and the Women's and Children's Hospital, and advanced radiology training in Oncology, Neuroradiology and General MRI at the Royal Adelaide Hospital.

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- Shoulder Imaging
- SAHMRI Oncology
- Liver Elastography
- Respiratory Imaging and Assessment
- Imaging of the Foot and Ankle
- Lower Back Pain
- Imaging the Injured Knee
- Cardiac Imaging Options
- Head and Stroke Imaging
- Thyroid and Breast Lumps

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To register for the GP Referred MRI event, visit [www.drjones.com.au/referrer-education](http://www.drjones.com.au/referrer-education) or contact Jenna Staltari on 0438 291 802.

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### Three generations of doctors: the Harris family

Dr Richard Harris became a household name for his efforts during the Thai cave rescue earlier this year. But did you know that his father almost drowned as a small boy?

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Architect: GHD Woodhead

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#### Production

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

#### Unsolicited material:

Unsolicited editorial material should be sent to the  
AMA(SA) c/- the Managing Editor no later than six  
weeks prior to the target month of distribution.

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William Tam



President's Report

## Health is a solution, not a problem

**A**S I write this, the KordaMentha reports are making waves, and the Opposition is making much of what they hold, and the implication of handing responsibility to a consultancy to “turn around” CALHN’s financial situation.

For an \$18 million contract it is hoped the plan will deliver savings of \$41 million by mid-next year, and \$101 million and \$134 million in the years following. On the agenda are “improving the efficiency of care”, in particular “unnecessarily long” hospital stays; better workforce planning; and increasing financial controls and accountability.

Reading some of the rhetoric about what is planned and what is hoped, I cannot help hearing echoes of some of the phrases, promises and objectives of the failed Transforming Health exercise. Of course, that was a much different branding exercise, with bright colours in place of shades of grey and blue, colourful pictures, a summit and a slogan. This one is more of an austerity sell, but still ...

The AMA(SA)’s take on all this, so far, has been that while we are in favour of efficiency, it must not be at the expense of patient care. We don’t want bed closures or a reduction in services to the community. We also strongly hold that if you are talking about improving efficiency, that needs to be driven by clinicians – doctors and others in the health team – not accountants.

Doctors know what is working well and what isn’t at their services, and they want to see improvements. Too often, they are not listened to.

We also need sound data to drive health policies and service planning. We have seen too many decisions driven by poor or poorly understood data, or inaccurate comparisons or benchmarks. That’s why the AMA(SA) has been calling for an independent clinical data analytics entity that can sit independent of government and SA Health, and provide sound information and analysis for sound decisions.

The need for better workforce planning, highlighted in the report, is something the AMA(SA) has been talking about for years.

What we don’t want to see, is for morale in our public system to continue its current trajectory. Cuts, reconfigurations, reforms, shiny new problems, and hoary old ones, have been adding up.

It’s not all doom and gloom though, and one of the risks in focussing on the fixes we want, the fixes we don’t, and the fixes someone has determined we have to have, is that we – including those in charge, and the public at large – lose sight of the great bits. And there are plenty of them.

We have amazing people in our system delivering fantastic care to patients, through all this. As doctors, we strive to do better, and we will. With help; without it; or in spite of it.

At the AMA(SA), our messages to the government and Department are to do this with us, not to us. Work with those who are on the front lines delivering care to patients on how our system can do better, and what comes next.

Too often, when we pick up the newspaper, or in our workplaces, or

even in the Parliament, it is almost as though Health – and our health system – is presented as a problem. It’s not a problem, it’s a solution.

It is not perfect. But every day it is making things – and people – better. Whether that is repairing broken bones or damaged bodies; picking up the aftermath of major trauma; or getting to the root of chronic disease.

There are things we need to fix in our health services, in our institutions and in how things are done. We are no orphans there. But we are ready to do that and we are ready to do that in a way that is constructive. We doctors like to fix things; it is what most of us get up for in the morning.

The AMA, both at state and national levels, is engaged in solutions. In public health, in policy, in law, in how the health system works, and beyond it. If you are an AMA member, you have a part in those solutions. You need them, your patients need them, and we need you. Your ideas, your priorities, and your membership dues. The AMA is not government funded. We are independent. We are beholden to no one except our members and to nothing except the ideals we uphold and promote, and the public trust that is afforded us.

Whether or not you are a member of the AMA makes a difference. It makes a difference for you, and for us. It is something you yourself can do for any of the many issues that concern you and the AMA as well. They will be many. If you are not a member now, please join today: [amasa.org.au](http://amasa.org.au). If you are a member, thank you!

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# Service cut will hurt the young, vulnerable and victims of abuse

THE AMA(SA) has spoken out in support of funding for important services that play a crucial role in helping the young and vulnerable in our state, with SA doctors rallying in a public petition to SA Health Minister Stephen Wade.

Not-for-profit SHINE SA has provided sexual health and relationship wellbeing services since its establishment in 1970, but has faced years of funding cuts: this year, a further 9.5%. In response, the service has taken the difficult decision to close its clinics in Davoren Park and Noarlunga (two of only four) and its city-based HIV counselling service.

"The AMA(SA) recognises that SHINE SA has made a difficult decision; we would like them to be able to reverse that decision," said AMA(SA) president A/Prof William Tam. "We are calling on the State Government and Health and Wellbeing Minister Stephen Wade to continue to fund these essential community services at SHINE SA."

"SHINE SA has been soldiering on in the face of successive funding reductions, including under the previous government, stretching as far back as 2012. These cuts hurt. The situation is now critical. What may to government be a short-term saving will have longer-term costs – financial and human. GPs and O&G doctors, among others, are extremely concerned, and we urge the government to hear those concerns and work with SHINE SA on a well-funded plan to protect the future of these important services," A/Prof Tam stated.

"The new State Government has shown leadership in health for children and young people by funding meningococcal vaccinations to protect them from this devastating disease. But STIs and unplanned pregnancies can also have huge repercussions on young people's lives and health," A/Prof Tam said.



## Mental Health Services Plan

PLANNING is underway by the Office of the Chief Psychiatrist and the South Australian Mental Health Commission to develop a new SA Health Mental Health Services Plan, to be delivered to the Government by March 2019.

Feedback has been sought on such issues as access to mental health services; defining best practice in mental health care; partnerships within and outside Government services; inpatient and community-based recovery and rehabilitation services; wellbeing, prevention and early intervention; and workforce.

The AMA(SA) is making a submission and welcomes ongoing feedback from members on this important area. Our past advocacy has included a broad scope, including the need for increased mental health beds; rural mental health services; appropriate home-like accommodation for people with severe chronic, transitional and acute mental health problems; measures for young people; and, in the wake of Oakden, three purpose-built facilities for people with severe behavioural problems associated with dementia, mental illness and impairment.

Members with any feedback are encouraged to contact us at [policy@amasa.org.au](mailto:policy@amasa.org.au).



Dr Philip Harding

Editor's

# LETTER

## AMA responds to National Rural Generalist Taskforce recommendations

THE AMA has submitted its response to the 19 recommendations of the National Rural Generalist Taskforce to Prof Paul Worley, the National Rural Health Commissioner. The AMA supports the development of a National Rural Generalist Pathway and its submission will inform further development of the National Rural Generalist Pathway (NRGP).

### The key points of the AMA submission were:

- strong support of the NRGF as a means of improving health outcomes of our rural and remote communities and in supporting improved recruitment and retention in these areas
- access to training in rural and regional areas will be key to the success of the program
- support for rural generalists to build upon high quality general practice with extended skills, including emergency medicine, in response to the needs of the community
- support for recognising rural generalism as a subspecialty within general practice
- continuity of employment for the duration of the training contract to provide stability and certainty to doctors on the Pathway
- conditional support for reform of the General Practice Rural Incentive Program, provided this comes with additional funding so that no GP or practice is financially worse off.

The AMA provided in principle support for rural generalist access to non-GP MBS rebates on the basis there is continued discussion and consultation with regard to defining scope of practice and credentialing.

## Failing to prepare for the health effects of climate change risks Australian lives

IN late November, the *Medical Journal of Australia* and *The Lancet* published a major assessment of progress on climate change and health in Australia, the *MJA-Lancet Countdown*. This report found that "Australia is vulnerable to the impacts of climate change on health, and that policy inaction in this regard threatens Australian lives".

The Australian Medical Students' Association (AMSA), the peak representative body for Australia's 17,000 medical students, joined with the *Medical Journal of Australia*, *The Lancet* and the Royal Australasian College of Physicians to develop a brief for Australian policymakers in response to the report's findings.

"Climate change affects human health in a number of ways, from the spread of tropical disease, increasing regularity of natural disasters to decreasing food security, all of which have consequences for human health," AMSA president, Ms Alex Farrell, said.

One of the brief's key recommendations was that all Australian medical school curricula should be updated to include the impacts of climate change on human health. This is necessary in order to build the health sector's capacity to help prevent and respond to the health impacts of climate change, the brief's authors wrote.

THE perils of ignoring or failing to learn from history are the stuff of philosophical and political catchphrase; but for such lessons to be learnt, it is first necessary to document and make available and visible the history itself. Hence the monuments which have been constructed and documents and volumes written throughout human history. For the AMA in South Australia, two recent events have brought this into sharp focus. Most recent is AMA(SA)'s move into its new offices and the problem of cataloguing and storing, let alone exhibiting, the enormous collection of portraits, documents and other memorabilia in Newland House going back to the early days of the SA branch of the BMA. Fortunately our Historical Committee, now chaired by David Fenwick, has put a lot of hard work into this task and this issue of *medicSA* marks the launch of their website, as detailed in the article on page 56, which includes a synopsis of Peter Kreminski's account of the committee's activities going back almost a century. The other event of significance has been the closure of the old Royal Adelaide Hospital which, because of its long history, has the largest repository of medical documents, photographs, artefacts and other memorabilia in the state. This material has largely been rendered safe by the RAH Heritage Committee and is in storage at the Hampstead Centre, but as a matter of government policy not one item of this collection has so far found its way to the new hospital, inspection of the walls of which will reveal no clue as to its long heritage at the original site.

As described on page 42, there are a couple of outstanding exceptions: the Cedar Prest stained-glass window from the hospital chapel has been saved as a result of the efforts of a group of dedicated and persistent nurses; and, at a more profane level, the legendary Jolly Bar has been relocated to a hotel near the nRAH, but the big picture is that South Australia needs and deserves a Health and Medical Museum. Representations for this have been made to the highest level of government and need the strong support of all concerned.



# Mandatory reporting: Australian Health Ministers failing on a promise

In November 2017, the COAG Health Council gave an undertaking to amend National Law so “that doctors should be able to seek treatment for health issues with confidentiality whilst also preserving the requirement for patient safety”. Unfortunately, despite the AMA and other groups responding to the consultation process with a united voice about how to achieve this, proposed changes to National Law appear likely to fail on this promise. **Dr Chris Moy** reports.



**P**ROF Steve Robson’s moving article<sup>1</sup> in *MJA InSight* on 22 October 2018, in which he revealed how close he came to taking his own life during internship, made plain the current problem: doctors are often reluctant to seek appropriate medical care because of a fear of mandatory reporting.

A doctor who is unwell, and their treating doctor, require certainty about the threshold at which reporting should occur, and that this threshold needs to be set at a level which provides adequate leeway for appropriate medical care to be sought.

Due to a lack of clarity, treating doctors often interpret the current National Law as setting a low threshold for the mandatory reporting of unwell doctors that they may see. As a result, and in seeking to limit their risk, treating doctors sometimes apply a ‘guilty until proven innocent’ approach in reporting situations where there is a low level of risk. It is understandable that an unwell doctor, faced with uncertainty in their understanding of the law and, more importantly, uncertainty about how a potential treating doctor will interpret the law, might be reluctant to seek appropriate medical care – too often with tragic consequences.

In response to the declaration by the COAG Health Council, the AMA argued strongly for national adoption of the Western Australian model, where there is no legal obligation for treating doctors to make mandatory notifications, or a ‘WA-lite’ model, where cases of sexual misconduct require reporting. Both offer certainty in practical application while showing no evidence of reduced patient safety.



Instead, by allowing treating doctors to begin from an ‘innocent until proven guilty’ position, but still requiring them to hold to ethical and professional responsibilities to not place the public at risk, WA legislation led to an increase in mandatory notifications from 12 in 2011-12, to 37 in 2015-16. This may well be because doctors who require treatment are more confident in seeking it, knowing that they will be fairly and consistently judged in regard to their risk.

The AMA’s advice was supported by major medical groups and also Kim Snowball’s 2014 Independent Review of the National Registration and Accreditation Scheme (NRAS) for health professionals which was commissioned by the Health Ministers’ own Advisory Council.

However, it became clear at the April 2018 Health Council meeting that the

Health Ministers had chosen not to listen. Instead, they proposed an unproven approach relying on setting a standard threshold for mandatory reporting to be expressed in legislation in each state.

During a further consultation period, Health Ministers yet again failed to heed advice from the AMA that any such legislated threshold – the ‘line in the sand’ – for mandatory reporting would need to be unambiguous to be of any benefit.

Essentially, the proposed legislation recently revealed in Queensland – the first state ‘off the block’ – sets a threshold of “substantial risk of harm” for reporting, while requiring the treating doctor to make a “holistic assessment” of risk: an overall assessment about an unwell doctor’s conduct relating to the impairment including, for example, their acceptance of treatment.

The AMA has responded that the Queensland Bill, as it currently stands, fails to remove ambiguity or improve on the current regime. For while “substantial risk of harm” raises the bar on the probability of harm for reporting, it provides no certainty with respect to the level, or severity, of the harm to be considered. For example, does the proposed definition encompass a situation where there is a substantial risk of the unwell doctor causing a low level of harm (such as inconveniencing a patient due to rescheduled procedures, or a delay in the writing of reports)?

So, the AMA has argued that, as a minimum, the legislated threshold test should be “substantial risk of substantial harm” – therefore defining both the likelihood and level of harm required for a mandatory report.

Inexplicably, the Explanatory Notes attached to the Queensland Bill “make it clear that only serious impairments that are not being appropriately treated are intended to require reporting” and that “harm would have to be

‘material’”. Although these Explanatory Notes have some weight in law, the reality remains that doctors are unlikely to comb through such documents, or rely on education material provided by the Regulator, particularly when they realise that the real ‘line in the sand’ will only be determined when we see how the law is applied in future cases.

**A doctor who is unwell, and their treating doctor, require certainty about the threshold at which reporting should occur, and that this threshold needs to be set at a level which provides adequate leeway for appropriate medical care to be sought.**

Health Ministers have failed to consider that a doctor in a consulting

room, with time pressures and the weight of responsibility of deciding the future of a colleague, needs simplicity and certainty about a fair threshold at which they need to report.

The AMA will continue to strongly advocate for a change to the proposed Queensland Bill that, under COAG processes, will dictate the laws in all remaining states and territories (except WA). However, if the Bill is passed without alteration, Health Ministers will have cast doctors adrift again in the same sea of uncertainty about mandatory reporting that we are currently forced to sail in.

*Dr Chris Moy is AMA(SA) vice president and chair of the federal AMA Ethics and Medico-legal Committee.*

#### References:

- 1 doctorportal.com.au/mjainsight/2018/41/learn-from-me-speak-out-look-for-help-get-treatment

## AMA(SA) calls for halt on mandatory drug treatment Bill for young people

**T**HE AMA(SA) has called on the government to put a halt on the controversial and flawed mandatory treatment Bill that it has put to the Parliament, which would allow for mandatory (court-ordered) detention and treatment for children for up to 12 months – with the capacity to extend further. It does not require the child or young person to have been charged with an offence.

The AMA(SA) has been in strong agreement with other professionals and key agencies who have opposed the Bill, including the Law Society of SA, the Guardian for Children and Young People, SACOSS, Uniting Communities

and the SA Network for Drug and Alcohol Services, and the statements made previously by the Commissioner for Children and Young People, among others.

“The mandatory youth treatment Bill currently before Parliament is a deeply flawed response. This is not the way to help young people grappling with drug-related issues,” said AMA(SA) president A/Prof William Tam.

“Aside from the basic premise of mandatory treatment being morally problematic, importantly there isn’t the medical evidence to support that it works for patients with drug addiction. In fact, the lack of evidence for mandatory treatment

as a care model is widely acknowledged across multiple sources.”

“The AMA(SA)’s overwhelming preference is for well-resourced voluntary treatment services, including more early support, education and intervention. We need to do more on prevention. We need to invest in proven measures. A Bill to introduce mandatory detention for vulnerable young people is certainly not an answer.”

Following a concerted advocacy push around the last sitting day for the year, just as *medicSA* went to press, debate on the Bill was adjourned to February.

# Maternity services must be obstetric-led and collaborative: AMA advocacy steps up

The AMA has made a submission to the Commonwealth Department of Health and Ageing on the proposed new National Maternity Services Strategy.

FEDERAL AMA president, Dr Tony Bartone, said that the AMA is adamant that national maternity services must use a collaborative care model that is led by obstetricians or general practice obstetricians.

Dr Bartone said that best-practice maternity care in the 21st century is provided by a multi-disciplinary team of health professionals.

“Obstetricians are the leaders and, along with midwives, are the key carers, but the team also includes general practitioners, anaesthetists, psychiatrists, obstetric physicians, pathologists, haematologists, paediatricians, and nurses,” Dr Bartone said.

“Current evidence supports that this model of care – led by an obstetrician or GP

obstetrician – is the safest for mothers and babies, and optimises a range of other health outcomes.

“Obstetrician-led or GP obstetrician-led care means that, at a minimum, there will be initial assessment by either an obstetrician or GP obstetrician, and assessment and regular review during labour. Models of care should not result in situations where obstetricians only become aware of a labour problem once it has become acute or serious. Women should be encouraged and supported to make their own choices.

“But they should be fully informed about the risks and benefits of each model as it relates to their own specific health situation, pregnancy, and

circumstances, after assessment by an obstetrician or GP obstetrician.

“GPs are often the health professionals who start the conversation with women about having children. GPs are best placed to provide continuity of care for women before, during, and after their pregnancies. GPs are especially important in providing whole of maternity care for women in rural and remote communities.”

Dr Bartone said that significant additional Federal Government funding will be needed to ensure safe, high-quality maternity services across Australia.

*The AMA submission is at [ama.com.au/submission/ama-submission-draft-strategic-directions-public-hospital-maternity-services](http://ama.com.au/submission/ama-submission-draft-strategic-directions-public-hospital-maternity-services).*



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# WCH move welcomed by AMA(SA)

After years of advocacy for a co-located Women's and Children's Hospital with the new Royal Adelaide Hospital, the AMA(SA) has welcomed the latest step along that road by the current State Government.

**A**FTER building speculation about the future location of the new Women's and Children's Hospital, the western end of the biomedical Precinct has been recommended as the preferred site for the new WCH by the Taskforce set up to plan for the move.

Lindsey Gough, CEO of the Women's and Children's Health Network, said the site meets all the criteria to ensure the needs of South Australian families are met for years to come.

"The site is an ideal position, co-locating the new WCH alongside the Royal Adelaide Hospital (RAH) and within the world-class Adelaide BioMed City," Ms Gough said.

As this issue of *medicSA* goes to press, the taskforce is just days away from finalising its report to government, due by 18 December. The report will include the bed numbers and service profile, which will be of particular interest to doctors.

SA Health has reported that the Taskforce worked with health planner Carramar to establish the size of the new hospital, and is confident it can be accommodated on this site. Architects GHD Woodhead provided additional advice on a range of sites identified by the Taskforce, which used an agreed set of evaluation criteria to analyse the options.

Advice from Adelaide Airport has reportedly confirmed the height of the building is in line with flight path guidelines, allowing for the site to be a viable option. Further work on the indicative cost estimate is ongoing and expected to be completed early in the first half of 2019.

The AMA(SA) sees the interim announcement as a welcome step towards the government's promise to deliver a new Women's and Children's Hospital co-located with the RAH, as promised in its pre-election policy platform. In fact, the move has been Liberal policy for some years now.

"The AMA(SA) has been advocating for this move across five presidents' terms of office," said AMA(SA) president



A/Prof William Tam. "We started talking about it in the lead-up to the 2010 state election and it has been on our list ever since.

"It has been a long journey to get here but we are tremendously glad to see this vital component of our health system moving forward," he stated.

"There are many great things to say about our current Women's and Children's Hospital, but it is an aging structure with clinical service limitations. The most critical issue that co-location addresses is that, in emergencies, pregnant women need access to specialist care they can't get on the present site. Co-location of the complete WCH package alongside the RAH will provide significant safety improvements for women, babies and children, as well as other benefits. Clinical safety has been the AMA(SA)'s consistent message and we are pleased our message has been heard.

"In fact, co-location is increasingly the norm, and what other services aspire to. There is much to be gained from it, and this really is an exciting opportunity," said A/Prof Tam.

"We have been hearing a lot about costs and the affordability of health lately; these need to be managed, but we are urging the people of South Australia to view a new WCH as an

investment in the future health care of our women and children."

Of course, it will be crucial that doctors and others involved in delivering care have a key role in the planning of the new Women's and Children's Hospital.

"We are all aware of the experience of the new RAH and the issues that arise when clinicians are ignored," said A/Prof Tam. "I hope the expensive mistakes of the past will not be repeated with the planning of this important asset, which will serve the future healthcare for women, babies and children in this state for decades to come.

"We also think it is timely that a new WCH stimulates a rejuvenated focus on a broader vision for children and young people, including dusting off the previous, abandoned work on a child health services plan for SA. We need a plan for children and young people that covers the spectrum from hospital to community care, including prevention and early intervention," he stated.

*The AMA(SA) will be reading the Taskforce's final report with great interest, when it is published, and members with comments or feedback are encouraged to get in touch with us at [president@amasa.org.au](mailto:president@amasa.org.au). Further information about the taskforce can be found at [www.wch.sa.gov.au](http://www.wch.sa.gov.au).*

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## *Exciting new developments have commenced*

**New additional operating theatre and refurbishment of recovery**  
(completed April 2018)



**New six bed Chest Pain Unit**  
(completed October 2018)



**New Day Procedure Unit**  
(concept image)



**Refurbishment of main entrance**  
(concept image)



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## *Exciting new developments have commenced*

**New Paediatric Day Stay Unit entrance – concept image**  
(commenced November 2018)



**New additional operating theatre**  
(commenced November 2018)



**Expansion of Pennington Terrace storage – concept image**  
(commenced November 2018)



**Refurbishment of patient accommodation**  
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# Young people on bullying: report from SA Commissioner for Children and Young People



In the December 2017 issue of *medicSA*, we reported on the work of SA's first Commissioner for Children and Young People Helen Connolly. The Commissioner's role was one that the AMA(SA) had lobbied hard for. Now, she has presented a new report – *The Bullying Project, what South Australian children and young people have told us about bullying* – to the Minister for Education.

**A** key objective of the SA Commissioner for Children and Young People is to position children and young people's interests, development and wellbeing front and centre in public policy and community life and to advocate to decision makers to change laws, policy, systems and practice in favour of children and young people.

When the AMA(SA) met with her late last year, the Commissioner had been conducting 'listening tours' across the state, meeting children and young people in a range of venues from shelters to youth groups to schools ... to talk to them about the issues that matter to them.

"I met with over 1400 children and young people who shared with me what is important to them and what they want to

see changed to make life better in South Australia," Helen said.

"The issue of bullying was raised in the context of what children and young people want to see changed and what they wanted me to prioritise in my work. They also discussed it in the context of the importance of friendships, acceptance, equality and wellbeing.

"Before I could 'do something' to stop bullying I needed more detailed information directly from children and young people on bullying. I therefore embarked on a 'bullying project' to find out what bullying looks and sounds like in 2018.

"I wanted to be clear about what 'it' is they wanted me to stop. I wanted to be able to inform decision makers what children and young people consider bullying is and to find out if they had ideas about solutions for

schools, parents and themselves to prevent and respond to bullying," the Commissioner explained.

The report seeks to place the views of children and young people front and centre in developing solutions to bullying.

"At the moment bullying – especially in relation to young people – is taking up a lot of airtime: on the radio, print and online media, at schools, communities and in all houses of Parliament," Helen said.

"However, the discussion is missing one vital element, the voices and views of children and young people and what they think the solutions are."

The report is a result of the Commissioner's consultations with almost 300 children and young people in schools and FLO agencies across greater Adelaide this year. It also comes after she took part in a roundtable discussion with the Attorney General's Department on bullying in South Australia.

*The bullying report is available here:*  
[ccyp.com.au/reports](http://ccyp.com.au/reports).

### Bullying report facts

- Bullying has been recognised by the United Nations Committee on the Rights of the Child as a form of 'mental violence'. This type of 'mental violence' can affect children's health, wellbeing, safety and security.
- What is different about bullying today, related to its '24/7' nature, is a result of social media and technology ... participants who felt bullying was worse discussed this in relation to the severity of the impact on their mental health as a result of increased bullying.
- Participants suggested anti-bullying programs need to include information on 'the consequences of bullying', 'depression' and 'mental health', including 'suicide'.



**Dr Gayle Silveira**



**Dr Linda Ferris**

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# New commissioners appointed: for aged care, and Aboriginal young people

Australia's first Aged Care Quality and Safety Commissioner has been appointed to lead the new and independent Aged Care Quality and Safety Commission; while a new South Australian Commissioner for Aboriginal Children and Young People has also been appointed.



## Australia's first Aged Care Quality and Safety Commissioner

Highly respected and experienced health sector leader, Janet Anderson will

oversee establishment of the Aged Care Quality and Safety Commission, as it prepares to start intensified compliance monitoring from 1 January 2019.

The new Commission will have a budget of almost \$300 million over four years, employing dozens of additional senior compliance officers.

The new Commission will integrate and streamline the roles of the current Aged Care Complaints Commissioner and the Australian Aged Care Quality Agency.

From January 2020, it will also incorporate the Department of Health's aged care compliance responsibilities.

The new Commission is a key part of the Australian Government's response to the recommendations of the Carnell-Paterson review of failures at the Oakden Older Persons Mental Health Service in South

Australia. A Bill to establish the Commission is currently in Parliament.

Ms Anderson will oversee the approval, accreditation, assessment, complaints resolution, monitoring and compliance of Commonwealth-funded aged care providers, reporting directly to the Minister for Senior Australians and Aged Care.

Ms Anderson has extensive management experience, particularly in the health sector, including leadership roles at state, territory and Commonwealth levels.

She was first assistant secretary, Health Services, in the Commonwealth Department of Health 2012-2015, and director, Inter-Government and funding Strategies in the New South Wales Department of Health 2006-2011.

For the past two years, Ms Anderson has held the positions of deputy chief executive and acting chief executive of the Northern Territory Department of Health.

In 2009, she was awarded the Public Service Medal for outstanding work in health policy development and reform.



## New SA Commissioner for Aboriginal Children and Young People

April Lawrie has been appointed the inaugural SA Commissioner for Aboriginal

Children and Young People, tasked with developing policies and practices to improve the safety and wellbeing of Aboriginal children and young people. Key areas of focus for the role include improving health, education, child protection and justice outcomes.

The new position has been created to monitor, advise and advocate on systemic and individual issues for Aboriginal children and young people.

Ms Lawrie has an outstanding track record of policy development and implementation across government and strong connections within the state's Aboriginal communities and organisations.

Most recently, she has been leading the development of the Education Department's Aboriginal Education Strategy and has also had senior roles at SA Health and the Attorney General's Department.

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# Strengthening the ‘weakest link’ in SA’s eating disorder services

SA can have a specialist eating disorder service that is among the best in the world, write **A/Prof Stephen Allison** and **Emeritus Prof Ross Kalucy**.

**T**HE AMA(SA) called for SA’s specialist eating disorder services to have a strong focus on youth health (‘Defragmenting specialist youth eating disorder services’, *medicSA*, Nov 2018, pp14-15). This call is important, because the acuity of eating disorders such as anorexia nervosa is highest amongst young people. Girls and young women aged 15 to 24 made most (58%) community mental health contacts, and required most (57%) hospital admissions for eating disorders during 2015-16, according to the Australian Institute of Health and Welfare.

Professor Pat McGorry from the National Centre of Excellence in Youth Mental Health at the University of Melbourne highlighted the peak in eating disorders in youth, and argued that clinicians and services should adopt a focus on early intervention (‘Paying the Price’, *Butterfly Report*, 2012, p1). Effective early intervention requires strengthening the ‘weakest link’ in our public mental health system, which is the transition from child and adolescent to adult services at age 17-18. This service break occurs during the period of peak acuity for anorexia nervosa when young women are most at risk of hospitalisation.

## The youth spike in eating disorders

Eating disorders might in fact be the paradigmatic youth mental health conditions that require the strongest transitional services in later adolescence. They appear to conform more closely to the youth model than chronic conditions such as schizophrenia and bipolar disorder, where acuity and service activity begin to rise in youth, but peak much later in life. Admission rates for all specialist inpatient psychiatric care are highest in mid-life with a peak for patients aged 35 to 44 years with similar admission rates for males and females, which

contrasts with the distinct spike in admissions among young women with eating disorders.

The reasons behind the youth spike in eating disorders are complex with both genetic and environmental factors playing a role in the increased risk after puberty. One powerful environmental trigger for disordered eating is weight-related peer-teasing amongst girls. Peer behaviours, including jokes about a victim’s weight and social exclusion, increase the risk of strict dieting especially among girls with a genetic vulnerability. Peer teasing among boys takes different forms, and produces different outcomes, although disordered eating and the use of drugs for weight loss appear to be on the rise among boys. More speculatively, recovery or partial recovery from eating disorders among young women after age 25 might be related to changes in the social environment, with the breakup of the female peer networks that help maintain disordered eating.

**“The combination of paediatric and adult psychiatric treatment available at FMC is particularly important for early anorexia nervosa.”**

Effective treatment for early anorexia nervosa is also socially based. It emphasises the role of parents, who are helped in systematic ways to encourage their child to eat, in order to restore her health and wellbeing. These family-based treatments can act as a counterweight to the behaviour of female peers that promotes dieting and weight loss. Favourable treatment outcomes rely on the strength of parental influence, and family based treatments are useful until later adolescence. Over this period, parental

support helps the young person to maintain her treatment gains.

## The Flinders eating disorder program

The eating disorder program at Flinders Medical Centre (FMC) has always had a strong focus on youth. The architectural design of FMC was fortunate for youth transitions with the Ward 4E paediatric unit and the Ward 4G eating disorder unit being close and friendly neighbours. Both clinical groups supported the youth transitional program for eating disorders through shared care and attendance at each other’s ward rounds. As a result, there was good continuity of care across both the FMC outpatient and inpatient programs for adolescent patients aged 17-18.

The combination of paediatric and adult psychiatric treatment available at FMC is particularly important for early anorexia nervosa.

FMC’s eating disorder program also emphasised shared care with GPs who provide the foundation for all treatment of youth eating disorders. GPs are well suited to the task, because there are no age barriers in primary care, and full integration of the physical and mental health aspects of treatment. But in return, GPs require eating disorder specialists who can provide continuity and availability, especially across the period of peak acuity in youth when management crises are more frequent.

Starvation has profound physiological, emotional and cognitive effects that interrupt the normal course of adolescent development. The first and most important issue is the restoration of normal eating and weight – a gradual process that parents are well placed to encourage, but in some instances requires either paediatric or adult medical inpatient admission, both of which are available at FMC. With weight



restoration and a post-pubertal physical status, the young person reencounters the physical and emotional changes of adolescence, and individual psychotherapy can help her to reflect on and respond to these developmental demands.

More recently, FMC's eating disorder program has expanded into SA's Statewide Eating Disorder Service, which has a well-functioning youth model of care. There is now the opportunity to add the last piece of the puzzle with SA Health commissioning a new statewide service for the family-based treatment of early anorexia nervosa. As the AMA(SA) recommended, this additional service should be integrated with the Statewide Eating Disorder Service, which will then be able to offer specialist treatment for patients across the entire life span. Internationally, it is recognised that specialist eating disorder services should be 'ageless', without a fixed service barrier at age 17-18, so they can offer 'seamless' treatment for young people (*Guidance for commissioners of eating disorder services*, Joint Commissioning Panel for Mental Health, 2013). This ideal is now achievable in SA.

*A/Prof Stephen Allison is a consultant child and adolescent psychiatrist and Emeritus Professor Ross Kalucy is consultant psychiatrist, College of Medicine and Public Health, Flinders University.*

## KordaMentha makes waves

LATE November saw the release by the State Government of what it described as a 'turnaround plan' for central Adelaide hospitals, in response to CALHN's budget woes. Advisory firm KordaMentha has produced a 'diagnostic review' and 'recovery plan' and has the contract to deliver the first stage of the plan, costing \$18 million and tasked to save \$41 million by the middle of next year and 'restore a balanced budget by 2021', with savings of \$101 million in FY20 and \$134 million in FY21.

The AMA(SA) has stressed that while it is in favour of efficiency, this must not be at the expense of patient care: we would not want to see bed closures or a reduction in services to the community. Also that efficiency should be driven by clinicians and informed by sound data – such as through the AMA(SA)'s proposed, independent clinical analytics entity.

"In one fell swoop CALHN has a new CEO, new governance arrangements with a new Board, and now a report by an investment advisory firm on how to do better," noted AMA(SA) president A/Prof William Tam. "It looks like we will be grappling with a fair bit of uncertainty at an already extremely challenging time."

"Further, KordaMentha had just four weeks for the 'Diagnostic' phase of its work on what is a major undertaking. Health services are complex and interrelated. We would think, more than a four-week exercise."

"We also note that the diagnostic report states that 'the current activity and financial budget processes result in inaccurate and unachievable budgets'. In this context, is it surprising if there are budget overruns?" A/Prof Tam said.

Concerningly, the initial statements from the government and CALHN around the KordaMentha report were somewhat demoralising for staff who are striving every day already to deliver the best care to patients. We hope this changes, and urge the government and SA Health to work with those who are on the front lines delivering care to patients on how our system can do better, and what comes next.

## A/Prof Nick Brook – Urological Surgeon

**Nick has returned to Adelaide after a sabbatical in Europe for six months, where he undertook advanced training in robotic urology surgery.**

He has a special interest in robotic Urologic Oncology, and chairs the Uro-Oncology MDT at the RAH.

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# A 2020 vision for health?

We have a new government that continues to advance its pre-election policy agenda, but there is quite a road ahead. Various reforms and changes are on the way, but the AMA(SA) wants to see more from the government than just delivering on its pre-election checklist and the day-to-day business of governing after that point. What would you like to see in place for 2020?

**I**n the lead-up to this year's state election, the AMA(SA) released its *People-First Health Strategy for South Australia*, outlining key priorities for action by government. Post election, we again underlined top themes and some tangible fixes in a pre-budget wishlist for what next, beyond the first 100 days.

We are glad to see that the government has been acting in some of these areas, but it is clear there is much more to do. An overview of just some of what we have been talking about this year is below, but we will be glad to hear from members on what you think needs saying and doing now, as the rubber hits the road on what will soon be year two under the new Liberal Government. What would you like to see from this government by 2020?

## The right care: clinician-led, clinically informed decision-making

The new State Government has embarked on its restructure of the SA health system with the introduction of regional health boards. The government has stated that its new model will improve clinical involvement through clinical engagement strategies, and health professional representation on boards. More is needed.

Our health system must make much better use of the clinical expertise in SA Health and beyond it, to inform policy and practice. In particular, we also need better data to inform better decisions by government and policy makers, and on the ground in our health services.

*>> The AMA(SA) calls for a Clinical Analytics Institute, and more clinician-led decision-making across the system.*

## Rural and remote health: No South Australian left behind

Approximately one in five South Australians live outside the greater Adelaide metropolitan area but statistically, many of these South Australians are at

a disadvantage when it comes to access to health care.

People living in regional, rural and remote Australia often struggle to access health services that urban Australians would see as a basic right. These inequalities mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities.

The AMA(SA) continues to call for a significant budget increase for rural and regional clinical services, infrastructure and workforce, including teaching and training, and grants for rural medical research. Some steps have been taken but more is needed.

*>> The AMA(SA) calls for a significantly increased budget for rural and regional clinical services, infrastructure and workforce, including teaching and professional development.*

## Children and young people: investing in the future

Children have been left behind in recent health policy. The best care of children and young people in this state requires a co-ordinated and planned approach. The AMA(SA) has long advocated for a Child Health Plan to guide future services and investment. It should address child health issues, including obesity, development and learning, behavioural problems and mental health, with a focus on prevention; it should involve both SA Health services and other government and non-government services; and it should be clinician-led.

A plan was previously under development for several years, but shelved. It is time to reinvigorate planning for children and young people so that the very positive move of a new, co-located WCH can sit within an overall plan for young people.

As part of this process we need a detailed clinician-led review of hospital and community services for children, with an

emphasis on equity of service provision. Early intervention and prevention services, in particular, must target those at greatest risk and must include pre-conception and prenatal services.

*>> The AMA(SA) calls for a Child Health Plan as a key priority, and the government must hold firm to its promise of a new, co-located WCH, and get the planning and consultation right.*

## Older South Australians, mental health, rights & wellbeing

The reports into Oakden highlighted galling failures in our state's care for older people. Oakden was the only service in SA providing services for people with severe behavioural and psychological symptoms of dementia and others needing similar care, such as those with brain damage through alcohol and drug use.

It is vital that the issues identified in the Oakden reports are addressed and the right services and protections put in place to ensure that vulnerable older South Australians receive safe, caring, appropriate care. The number of such patients is expected to grow significantly over the next 10 years, requiring urgent planning to ensure they can be managed with safety and dignity.

We also need better dementia care pathways overall, including for the transfer between hospitals and aged care, and better interfacing between the public system, and aged care and the private sector. Better use of data would also support this. The need in this area is only going to grow in the future: the time to act is now.

*>> The AMA(SA) calls for three purpose-built facilities for people with severe behavioural problems associated with dementia, mental illness and impairment, and specialist training for staff caring for elderly patients with behavioural problems.*

## Integrated hospital & GP care

Best practice health care recognises the need for seamless care for patients from hospital to home. It also requires tailoring health services to meet the needs of individuals rather than asking them to navigate a system built around funding models.

A multi-disciplinary, integrated approach is needed to develop communication protocols and pathways to support transition from hospital, aged, step-down, mental health and palliative care. This would reduce pressure on inpatient and outpatient services and produce a better patient experience.

The AMA(SA) has advocated for state-supported home care using GPs and allied health, based on collaborative team-based shared care between GPs and hospitals, and triaging GP referrals. This means adopting the AMA's guidelines to improve transfer of care plans and the patient journey from hospital to general practitioner care as well as developing appropriate Commonwealth-state funding models.

>> *The AMA(SA) calls for collaborative team-based models of care between GPs and hospital staff, and funding for GP-led stepdown/outpatients, supported by responsive community nursing.*

## Heal the healers: doctors' wellbeing, and system culture

The AMA is deeply concerned about the issue of doctor suicide and mental health within our profession. There has been increased public attention to this issue, which is a good thing. It is vital that medical practitioners are able to find support from their peers through mentoring, or from mental health professionals, without jeopardising their career.

Safe working hours is also a crucial workforce issue that the Government must commit to, for city and country.

Finally, we need to develop a culture of respect and support for all health professionals. The AMA(SA) is aware of reports of a bullying and oppressive culture within SA Health. We call for a commitment to overcome the current negative culture

in our public service. Open, honest and respectful relationships between the bureaucracy, the health professionals and the public are vital for a healthy public system.

>> *The AMA(SA) calls for funding for a mentoring program for doctors and medical students, particularly in rural areas, and peer-to-peer support networks for all doctors but especially doctors in training; and commitments to safe work hours and zero tolerance of bullying.*

These are just some of the theme areas the AMA(SA) has been pursuing. We are also emphasising that while budget woes and system pressures are in the headlines, what we need is solutions, not politics and the blame game.

Health professionals and the AMA(SA) stand ready to be part of the solutions, and we look forward to hearing more from our members on what you see as the top issues for health in this state. You can email us at [policy@amasa.org.au](mailto:policy@amasa.org.au), and find out more about state and federal AMA(SA) advocacy on our website: [amasa.org.au](http://amasa.org.au).



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# Closing the Gap strategy unravelling – time to rebuild, not refresh

The AMA Indigenous Health Report Card 2018 – Rebuilding the Closing the Gap Health Strategy was launched in November.

**T**HE Closing the Gap Strategy is unravelling, and must be rebuilt from the ground up to have any chance of closing the life expectancy gap between Indigenous and non-Indigenous Australians, Federal AMA president, Dr Tony Bartone, said at the launch of the Report Card.

The Report Card is the AMA's annual analysis of an area of Aboriginal and Torres Strait Islander health across the nation. This year's Report Card scrutinises the 10-year-old Closing the Gap Strategy, and recent efforts to 'refresh' the Strategy.

"It's been a decade since the Council of Australian Governments (COAG) launched the Closing the Gap Strategy, with a target of achieving life expectancy equality by 2031," Dr Bartone said.

"But 10 years on, progress is limited, mixed, and disappointing. If anything, the gap is widening as Aboriginal and Torres Strait Islander health gains are outpaced by improvement in non-Indigenous health outcomes.

"The Strategy has all but unravelled, and efforts underway now to refresh the Strategy run the risk of simply perpetuating the current implementation failures.

"The Strategy needs to be rebuilt from the ground up, not simply refreshed without adequate funding and commitment from all governments to a national approach."

The Report Card outlines six targets to rebuild the Strategy:

- committing to equitable, needs-based expenditure
- systematically costing, funding, and implementing the Closing the Gap health and mental health plans
- identifying and filling primary health care service gaps
- addressing environmental health and housing
- addressing the social determinants of health inequality
- placing Aboriginal health in Aboriginal hands.

"It is time to address the myth that it is some form of special treatment to provide additional health funding to address additional health needs in the Aboriginal and Torres Strait Islander population.

"Government spend proportionally more on the health of older Australians when compared to young Australians, simply

because elderly people's health needs are proportionally greater," Dr Bartone said

"The same principle should be applied when assessing what equitable Indigenous health spending is, relative to non-Indigenous health expenditure.

"The Australian Institute of Health and Welfare estimates that the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden, meaning that the Indigenous population has 2.3 times the health needs of the non-Indigenous population.

"This means that for every \$1 spent on health care for a non-Indigenous person, \$2.30 should be spent on care for an Indigenous person. But this is not the case.

"We will not close the gap until we provide equitable levels of health funding. We need our political leaders to tackle the irresponsible equating of equitable expenditure with 'special treatment' that has hindered efforts to secure the level of funding needed to close the gap."

*For more information, go to [ama.com.au/article/2018-ama-report-card-indigenous-health-rebuilding-closing-gap-health-strategy-and-review](http://ama.com.au/article/2018-ama-report-card-indigenous-health-rebuilding-closing-gap-health-strategy-and-review).*

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## 2019 AMA Indigenous Medical Scholarship – call for applications

**A**PPLICATIONS are now open for the 2019 AMA Indigenous Medical Scholarship, a program that has supported Aboriginal and Torres Strait Islander students to study medicine since 1994.

The successful applicant will receive \$10,000 each year for the duration of their course.

Federal AMA president, Dr Tony Bartone, said that previous recipients have gone on to become prominent leaders in health and medicine, including Associate Professor Kelvin Kong, Australia's first Aboriginal surgeon.

"Closing the disgraceful gap in life expectancy and health outcomes between Indigenous and non-Indigenous Australians requires real action from all levels of government, the private and corporate sectors, and all segments of our community.

"This Scholarship is a tangible step towards addressing the shortage of Indigenous doctors."

Applications close on 31 January 2019.

Further information, including the application form, is at <https://ama.com.au/indigenous-medical-scholarship-2019>.

The AMA Indigenous Medical Scholarship was established in 1994 with a contribution from the Commonwealth Government.

The AMA is seeking further donations and sponsorships from individuals and corporations to continue this important contribution to Indigenous health. If you are interested in making a contribution, please go to [ama.com.au/donate-indigenous-medical-scholarship](http://ama.com.au/donate-indigenous-medical-scholarship).

*For enquiries, contact [indigenousscholarship@ama.com.au](mailto:indigenousscholarship@ama.com.au) or (02) 6270 5400.*

# Why AMA membership makes a difference

All doctors know that not all doctors are AMA members. The public largely expects that their doctor is. Membership is tied to a sense of legitimacy, professionalism, ethics, and standards. But it confers more than just that ...

## 1. We'll stand up for you

Sometimes it can feel like you're under siege, or at least engaged in some war of attrition. Bureaucracy, governments, health insurers, politicians, the media. Bad policy, cuts, paperwork, bad news and more. The AMA(SA) is a voice for doctors in all this, saying the things you would like to, and fighting your corner. If you have a problem, you can bring it to us and have the weight of the AMA behind you. And if you need it to be confidential, it is. Some of our best successes are known by the smallest number of people. That's not because we don't like credit: it's because we put our members first.

## 2. We do it so you don't have to

There is a lot going on all the time – Bills before Parliament; government reviews; Department of Health directives, disappointments and the odd debacle; changes being brought in that will affect you and your patients; people and services in trouble. Every day, decisions are being made about things that matter, but you don't have time to keep on top of it all. After all, you have patients to see, hopefully some life outside work, and other things to do. While you are doing those things, we are working on the rest – with the help of members like you, and our state and federal staff teams.

## 3. Resources, benefits and advice

The AMA covers the gamut of practice, from student and intern years through to later career stages, and across all the specialties. We provide a large array of resources for all sorts of useful things, from practice matters, through to other tools and services that make your life easier. Some of these are AMA state and federal materials such as the

very popular national 'Fees Book' – available electronically and easily for practice software these days. Others are services and other benefits from service providers: accounting and legal firms, Qantas and Virgin, and the Ambassador Card for entertainment offers, to name just a few. We also provide advice to members on all sorts of questions and problems, big and small. Call us and see!

## 4. Being in the know

The AMA is a formidable source of information: we are vigilant on state and federal developments that you need to know about, and conversations big and small that matter to our members. The AMA is an opinion leader and it is also a melting pot of what's going on in health. As a member, you have access to information and news that you won't necessarily find elsewhere. You don't have to read it all, but you have it all open to you. State and federal updates from *medicSA*, the *Voice*, *Australian Medicine* and our GP and DiT national email newsletters, the *Medical Journal of Australia*, and more.

## 5. We can vouch for you

The AMA is seen as an authority on all sorts of things – pretty much anything that comes under the health banner, in fact. We get asked about a lot of things and that may include you, your practice, your charity, a coroner's case you have been involved with, or some media story – good or bad. We get asked about people who are up for awards and honours. When doctors go to politicians or the media on something that matters to them, often we get asked about the merits of that case, the credibility of that person. If we know you, we can vouch for you. We can attest to what we know. We can call you and find out what's what. We will want to do



what we can stand by you, our member. And we will.

## 6. It's a message about what you stand for

Everyone wants a slice of health these days, it sometimes seems. The sales pitches for wellness and health are everywhere, peddled by all sorts, but we need to be clear with our patients and the broader community on what medicine stands for. The AMA promotes and upholds the high standards our profession aspires to. By standing with us as a member, you show that you identify with, and stand by, those standards. As a member, we provide you with tangible symbols of those standards through things such as our AMA Declaration of Geneva certificates for practice rooms, and the AMA membership pin and postnominals. Including your AMA membership or involvement in your professional information shows that you care, and caring matters. It can make all the difference.

To find out more about AMA(SA) membership or to join or renew, visit our website at [amasa.org.au](http://amasa.org.au) or call Karen on 8361 0108.

# High stakes today for the future of medical education tomorrow

Twelve months have passed since senior Flinders medical students and Flinders Medical Students' Society (FMSS) representatives **Stephen McManis** and **Riche Mohan** reported on the sweeping change afoot at Flinders University ('The future of medical education today', *medicSA*, Dec 2017, p19), and the turbulent period of transition the medical program found itself in. Now, on the cusp of graduation, the two reappraise the Flinders program and describe their high hopes for the future of the course.

**T**HE Flinders medical program remains enlightened in pedagogy and firmly on the cusp of excellence. Successive iterations of the Flinders curricula are frequently bought by other aspirational institutions – but there's a problem. While the faculty, our clinical leads, and our program director work tirelessly to propel the course forward, the university-wide restructure has not only reinforced the concerns these authors voiced for the program some 12 months ago, it now threatens the sustainability of the course's essential clinical and academic contributors, and has significantly promoted an emerging crisis of mental health within the student cohort. In an era when we are trying desperately to rewrite the narratives around medics' wellbeing in medicine, our students describe extreme, chronic distress, affecting their ability to learn, to grow, and ultimately, to graduate to healthful, exemplary practice. An ambitious program needs to be adequately resourced.

Indeed, progress in the academic structure of the course has seemingly outstripped its resourcing, and both faculty and students alike have found their daily milieu characterised by a toxic uncertainty. This strain is hugely deleterious to the output of both staff and students, and anathema to the stated goals of the college and its university. There is important context to the change – while the pursuit of progress carries risk, Flinders can hang its hat on some definite historic achievements:

- It was one of the first in Australia to adopt a graduate-entry model, and craft and sell a PBL curriculum.
- It was the first in Australia to graduate MDs, with the inclusion of core research curricula (Advanced Studies).

- It was one of the first to move from PBL to large-group teaching cycles, assessed weekly, under Team Based Learning and more broadly under Programmatic Assessment for Learning (PAL) which aims to do away with single-point, high-stakes examinations in favour of frequent, low-stakes assessment.
- In 2017, Flinders assessed its students with the Progress Test for the first time, a vast, negatively-marked MCQ exam, sat quarterly by all students and graded by cohort means derivations, rather than by an imposed pass mark.

The restructure represents a tremendous loss of personnel, and years of wisdom which, in effect, held the course together ...

These latter evolutions of the course have occurred while the university itself transforms to a collegiate system, centralising services and homogenising professional staffing, which has dramatically changed the resourcing available to it. To say it has been challenging for both the medical students and our faculty would be a vast understatement; the fact is that our core academic and clinical educators are trapped in a cycle of increasing administrative workloads while professional staffing, already stretched, has been further affected by the restructure, with new and unfamiliar people expected to do complex work for the program (i.e. audit and review the progress test, comment on assessment, understand clinical versus non-clinical student expectations) and work across the college, where

previously, staff would have operated within discreet roles within the medical course alone. The restructure represents a tremendous loss of personnel, and years of wisdom which, in effect, held the course together through transition. From our perspective, what the university seems unable to recognise or value is exactly that which makes Flinders synonymous with academic, ethical, and clinical advances in medicine – its people.

Indeed, the concerns we described in the previous article would be compounded by a slew of proposed changes. Flinders is repositioning as a soundly future-focused institution, but in prioritising research, implementation of new educational methods haven't been provided adequate supporting frameworks to facilitate such transition. Of particular concern for our members is the provision of adequate teaching and support for anatomy and histology, clinical skills, and medical ethics; among others, these appear especially vulnerable at this time with uncertainty around how these roles will be described or filled. Crucially, we need the university to show our members they are a valued part of the Flinders institution, with the proper provision of student welfare services and an active medical student welfare committee.

While we observe much of what our ambitious directorate and faculty have had to endure these past 18 months, we can only speak on behalf of students. Where clarity has been lacking due to pending high-level decisions and structural stress, profound student anxiety has accumulated. Concurrently, the shift to fewer staff and the new absence of PBL-group tutors in year 1 and 2 also means fewer points of support for students, and a limited



ability for students who are suffering to be brought to the appropriate attention of the faculty – and undeniably, some of our students have been suffering.

FMSS surveyed all four year levels over the past two years, showing significant distress across the cohorts. Sadly, our survey also saw a picture of an eroded sense of meaning and hope, with an alarming number of people disclosing frequent emotional crisis, suicidal ideation and self-harm. This is an incredibly serious issue, and FMSS cannot claim to be an advocacy organisation without addressing it with commensurate sincerity.

Indeed, there are benefits to an assessment system with something of an identity crisis – graduating Flinders students in 2018 have successfully been assessed by two systems, and our program boasts some of the most examined medical students in Australia. Unfortunately, the stakes appear too high; recently, our vice president lamented, “No one here is studying for the love of medicine anymore ... they study for survival ... and that sword dangling over our heads.”

Our medical students shouldn't be so jaded. To build support and wellbeing back into medicine, FMSS, supported by the AMA(SA), launched a program-wide, senior-student to junior-student mentorship program just this year. FMSS continues to fiercely advocate for all of our members, and in doing so, we have had to advocate for our faculty, for the resources required by our directorate, and for the adequate staffing of the program; for it is in their diligent work that our program will flourish, and our enrichment as people as well as practitioners will be for the ultimately outstanding care of our future patients, and the safety and prosperity of our community.

Through this challenging period for Flinders medicine, we'd like to acknowledge our deans, course director (see her article on page 22), our strategic professor of med. ed., and year 1-2 directors and year 3 coordinator in particular, for their vigorous support. The goal we all share for the realisation of the program will take us far.



Equally, with a hopeful view for the future of Flinders, we note the advocacy landscape for the incoming FMSS committee remains a bountiful one, and we wish them all the very best for a constructive year. The class of 2018 graduate with our sincere congratulations for our shared resilience and determination: may

the lessons acquired through such trials equip us for the most meaningful, inspired and rewarding careers in medicine.

See you on the wards.

*Stephen McManis is president, FMSS and Riche Mohan is graduation coordinator, FMSS.*

**Dr Tom Wilkinson** MSc MDS  
Specialist Prosthodontist

**Dr Melissa Laohachai** BSc BDS

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- Assessment of bite and tooth wear problems
- Patients requiring dental devices for snoring and apnea

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# A rationale for change...

In setting an ambitious agenda of positive change, Flinders University and the College of Medicine and Public Health have adopted strategies that will see increased resources more adroitly applied to enable Flinders Medicine to continue to improve upon its track record of innovation and excellence in medical education. By **A/Prof Tina Noutsos**.



**F**LINDERS is committed to developing exceptional graduates equipped with the highest technical and critical thinking skills. This requires us to create an environment where the highest calibre staff are supported to share their academic and clinical expertise with new generations of medical professionals. The creation of teaching specialist roles will enable our very best educators to focus their talents on teaching excellence, enhancing learning and the student experience.

Founded on a tripartite model of integrated clinical, education and research practice to make a difference to health and society, we are a university of firsts – the first post-graduate entry medical course in Australia, the first to move to Problem Based Learning, one of the first to graduate MDs in Australia, and the first to offer a longitudinal parallel clinical program in a rural setting – but we recognise improvement isn't borne of standing still and we must work hard to keep Flinders at the forefront of medical education.

More recently the Flinders Medical Program has joined a vanguard group implementing programmatic assessment for learning (PAL). PAL integrates many assessment moments into richly informed decisions of progress against defined learning outcomes. Students are expected to demonstrate satisfactory progress against each and every learning outcome, including those relating not only to knowledge and clinical skills, but also to professionalism and self-regulated learning. It includes a progress test, which repeatedly assesses students against all the knowledge required of a graduate (including both the basic sciences and clinical sciences), offering both rich feedback and opportunities for remediation.

Aligned with this new approach to assessment, we've moved to Team Based Learning, which uses a flipped classroom model of learning. In our digital age, the flipped classroom enables us to best utilise face to face time, with preparatory 'homework' of recorded lectures and pre-readings, followed by face to face time with content expert educators and clinicians facilitating sessions involving the application of knowledge to complex problems. This approach is not unique or new in medical education, and also used in a growing number of medical schools including Harvard and Singapore.

“These structural changes – to our course, our college and our university – are geared not towards prioritising research at the cost of education, but towards fostering excellence in both.”

These structural changes – to our course, our college and our university – are geared not towards prioritising research at the cost of education, but towards fostering excellence in both. The research environment is important to our students undertaking an MD that is to prepare them for evidence-based practice and the rapid growth of knowledge. Flinders' success as the ninth most funded medical research institution in the 2018 NHMRC round supports our medical students. We are proud to see our medical students publishing high quality papers so early in their careers, including recent papers in *Nature*, and *The Lancet*.

The health and wellbeing of our students is a priority. Each receives a learning coach for the duration of the

medical course, and a mentor from year 2 of their program. Workshops for students focussing on resilience and self-care are run jointly by medical course staff and university counsellors. Our Student Wellbeing Committee is focussed entirely on supporting students in difficulty, and an eMental health officer offers online support. A recent increase in counselling staff provides more opportunity for face-to-face support. The university has also recently established an out-of-hours service to ensure that students can access support at any time.

A strength of the Flinders MD is the value given to the student voice and our partnership with students. Our vision for change is based on inclusivity, and all the benefits that brings for our students, staff and the communities we serve.

*A/Professor Tina Noutsos BSc BMBS FRACP FRCPA is head of Medical Program, College of Medicine and Public Health, Flinders University.*

## Why I am a member of the AMA



**Bob Goldney AO**  
Emeritus Professor

Medical practitioners

are individuals who pursue diverse careers, and the only unifying voice is the AMA. In joining we become part of a long tradition which is continually seeking to improve not only the care of our patients and medical services, but also our own welfare.

# AMA(SA) supports students to preserve the future of Flinders Qualifying Ceremony

The AMA(SA) stands alongside Flinders Medical Students in advocating for the future of the Flinders Qualifying Ceremony, writes **Dr Chris Moy**.



**T**HE Flinders Medical Qualifying Ceremony has been a treasured event for the graduating Flinders medical students and

their families for many years.

Separate to, and less formal than, the Graduation Ceremony, the graduating students have the opportunity to invite their wider family and friends to attend and observe them taking the Physician's Oath, and to share in the joy of the presentation of awards (including the AMA(SA) Student Medal) for achievements by both students and teachers. It is an emotional and inspiring event that brings together the students one final time – and acts as a galvanising memory as they set off on their careers as doctors.

So, it was with deep disappointment and surprise that AMA(SA) was alerted by the Flinders Medical Student's Society (FMSS) to a decision that had been made by the university, without prior consultation, to cancel the Qualifying Ceremony for this year and into the future, with the only consolation being the offer of a transitional event in 2018, but excluding the Physician's Oath.

This has occurred in a tumultuous period for the Flinders medical program, as outlined in the article by Stephen McManis and Riche Mohan (see pages 20-21). The article reflects some of the concern and distress that students have felt about the level of support and consultation that they have been provided, and that some have perceived that there has been an overall direction to homogenise the medical course to fit more neatly, from a resourcing and efficiency point of view, with the other health sciences courses.

In addition, the decision to cancel the Qualifying Ceremony was made when many of the family and friends of the graduating students had, understandably, already arranged travel to attend the event.



With the unequivocal support of the AMA(SA), the FMSS has been able to negotiate the reinstatement of the 2018 Qualifying Ceremony, to be held on 17 December. However, they have been told that this will be the last Flinders Qualifying Ceremony.

Some of the reasons that the students have been given for the decision have been ones surrounding 'equality' for other health science students who do not have a similar event, and, despite not being asked beforehand, that the taking of the Physician's Oath by medical students in front of the other health science graduates would somehow be 'more meaningful'.

The AMA(SA) remains in strong support for the FMSS in advocating for a reinstatement of the Flinders Medical Qualifying Ceremony in 2019 and in future years. In response to the recent decision, the AMA(SA) Council approved the following motion:

*The AMA(SA) supports an independent ceremony for all medical graduates which requires the swearing of the Oath and recognition of individual merit by award. Such ceremonies are to be conducted in the presence of family, friends and such representatives of esteemed professional bodies and colleges of medicine, as determined by the faculty and students*

Many universities which do not have a medical school have sought to have one because of the prestige that they bring to their institutions. Much of this has to do with ethics and standards of professionalism that are enshrined in medical training and being a doctor. These are elements that, in many respects, other health professionals aspire to, and strive for.

Sadly, and along with other changes that have occurred at the medical school, this recent decision may be seen by some as one which risks devaluing the university's medical course.

The AMA(SA) believes that the proposed changes would not only be detrimental to the reputation and tradition of the Flinders University medical program but would also cause significant distress to students and their families.

The AMA(SA) will continue to support the FMSS in requesting that the tradition of the Qualifying Ceremony continue into the future, not only because it is an event which has great symbolic value to the students of the Flinders University medical program, but also because, as doctors, we stand up for each other.

*Dr Chris Moy is vice-president, AMA(SA).*



# AMA(SA) Council NEWS



**Dr Shriram Nath**  
Councillor

AMA(SA) Council Meeting  
November, 2018

**T**HE November AMA(SA) Council meeting started with the welcome to the country. Dr David Fenwick and Dr Peter Kreminski from the AMA(SA) Historical Committee presented their ongoing work to the Council. The shift from Newland House to the new premises (AMA House) has led to a busy time for the volunteers.

The Historical Committee is involved in determining how best to preserve the oil paintings of the past presidents and old documents relating to the AMA(SA). Many documents have been scanned and digitally preserved. The plan is to link them to the AMA(SA) website.

One of the limitations of new buildings is that they have little space to hang oil paintings, as there are many more windows to the exterior, and sometimes

low ceilings. The challenge would be to preserve and display the oil paintings. There was brainstorming, and ideas floated, including displaying them temporarily in art galleries at the Flinders Medical Centre and the new Royal Adelaide Hospital, for example.

Membership is always a challenge. Advocacy issues pertaining to the medical community and population at large are taken up by the AMA on behalf of members and non-members. A lot of thought, time and energy is spent in preparing the background work, which is invisible to members and non-members. Using social media and technology may be the way, in future, to improve our reach to members and non-members.

This may be the last year of the rich tradition of the Qualifying Ceremony for medical students at Flinders University, where prizes are given and the Physician's Oath is taken by successful students who are ready to step out into their medical careers. The Flinders Medical Students' Society, with the

backing of the AMA(SA), has seen the Qualifying Ceremony obtain a reprieve for this year. In future, the plan by Flinders University is to include these aspects at the Graduation ceremony, where no prizes are awarded by faculty, and this unilateral decision is largely opposed by the medical student community.

The challenges thrown by the legacy of Transforming Health and the nRAH to the medical staff were discussed. The opening of new beds was welcomed. The challenge for SA Health would be to have a new electronic medical record system which is easy to use by clinical staff. The challenges of the efficiency of SA Pathology, which may lead to job cuts in the government service, were also discussed. At the RAH, the Sleep Unit was not shifted along with the Chest Unit to the new hospital, which could lead to decreasing the time accredited to the training of the physicians of respiratory and sleep medicine.

All in all, it was a full meeting, as we prepare for the year's end and a new year to come.

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Online referral forms at: [www.fastrackcysto.com](http://www.fastrackcysto.com)

Calvary

North Adelaide Hospital



# AMA(SA) dispatches



## AMA(SA) Christmas closure

The AMA(SA) office will be closed from lunch on Friday 21 December, reopening on Monday 7 January 2019.

## Membership renewals

It is renewal period, with invoices sent to members recently. Membership renewals fall due on 31 December each year. We hope that you have made the most of your membership this year – and if you have any suggestions about what services or benefits you would like to see us incorporate as part of AMA(SA) membership, let us know.

## AMA(SA) Council meetings

Meetings of the AMA(SA) Council are open to all members. The AMA(SA) Council meetings are held monthly, excluding the months of January, April, July and October. The next meeting will be held on Thursday 7 February. Any member wishing to attend a Council meeting should contact Claudia Baccanello on [claudia@amasa.org.au](mailto:claudia@amasa.org.au) or 8361 0109.

## AMA Roll of Fellows for 2019 – Nominations for Admission

Nominations for admission to the Roll of Fellows of the Australian Medical Association are being called.

*Nominations need to be in writing and accompanied by a written citation.*

Nominations are strictly confidential and should be received by the AMA(SA) no later than 7 January 2019. For details of guidelines, definitions and conditions, please contact Claudia Baccanello on 8361 0109 or [claudia@amasa.org.au](mailto:claudia@amasa.org.au).

## 2019 AMA(SA) Charity Gala Dinner

The AMA(SA)'s 2019 Charity Gala Dinner will be held on Saturday, 11 May 2019 in the Panorama Ballroom at the Adelaide Convention Centre. This year we will be supporting Foodbank SA, a charity whose core concept remains simple – to feed those in need by redistributing surplus food. Online ticket sales to open in the New Year.

## Looking after you: calling for doctors on paternity or maternity leave

PlaygroupSA sessions will be commencing in early 2019 for doctors on parental leave. The aim of these monthly playgroups is to provide a secure play session for our members' babies and children, while parents network and learn from each other. To register your interest for a playgroup session, email [membership@amasa.org.au](mailto:membership@amasa.org.au).

## AMA Code of Ethics

AMA Code of Ethics online learning provides greater clarity on consent, conscientious objection, complaints, control of patient information, fees, professional boundaries, managing interests, stewardship, medico-legal responsibilities, and protecting others from harm. Accreditation via AMA Provider 621057. Go to [learning.doctorportal.com.au/catalogue/module-details/205](http://learning.doctorportal.com.au/catalogue/module-details/205).

## Save on petrol

We are pleased to welcome our latest choice in eGift Cards for our members, the Caltex StarCash Digital eCard! With more than 1,900 service stations across Australia, we are confident there will be a location near you. Save 5% on StarCash Digital when you purchase online. Access from your Smartphone via [ama.ambassadorcard.com.au](http://ama.ambassadorcard.com.au).

## Member benefit: need career coaching?

Give 1300133655 a call and book a time with Anita. For our doctors in training, we recognise that you need to gain the edge when applying for positions – we can help you create an application that will have you standing out from the crowd. Go to [ama.com.au/careers/career-coaching](http://ama.com.au/careers/career-coaching).

## Is your data correct?

Early career doctors are encouraged to review their membership account to ensure details kept on the AMA(SA) database are accurate. The lag over from your student days could mean we still have your student email listed, for example. To rejoin and rectify, simply contact [membership@amasa.org.au](mailto:membership@amasa.org.au).

## Find a doctor

This is the place to go when you want to find colleagues and specialists for a referral. It enables you to search for a doctor, anywhere in Australia, by name, address or discipline. The search provides a doctor's name, specialty, current practice contact details and a scalable map that can be printed and provided to patients. Go to [doctorportal.com.au/find-a-doctor](http://doctorportal.com.au/find-a-doctor).

## Are you registered?

AMA(SA) works with the Law Society of SA to improve access to medical specialists for ReturnToWorkSA, Allianz and public liability claims patients – particularly in the areas of spinal surgery, neurosurgery, ophthalmology and psychiatry. The AMA(SA) register comprises practitioners who are prepared to undertake medico-legal consultations and reporting. If you are interested in being included on the register, please email [membership@amasa.org.au](mailto:membership@amasa.org.au). Member listings are free. Go to [ama.com.au/sa/amasa-medico-legal-register](http://ama.com.au/sa/amasa-medico-legal-register).

## AMA members discount on Avis vehicles

The AMA has partnered with Avis Budget Group to give members special access to a 10% discount off daily rates when renting vehicles.

Whether you're travelling for work or leisure, you'll be able to book the perfect vehicle for your needs at discounted rates throughout Australia and abroad.

- 10% off daily rates (AMA members only)
- Access to thousands of latest model vehicles across the country
- Earn Qantas Points\*
- Rent through a convenient, extensive network of 230+ locations in Australia and over 5,500 locations globally
- Access discounted international rates.

For more information, contact AMA Member Services: 1300 133 655 or [memberservices@ama.com.au](mailto:memberservices@ama.com.au).



# Past presidents, life and retired members annual luncheon

AMA(SA) president A/Prof William Tam and chief executive Joe Hooper welcomed past presidents, life and retired members to the Gilbert Suite at the Adelaide Convention Centre on 5 November for the annual AMA(SA) luncheon – a highlight of the AMA social calendar.

**T**HIS year A/Prof Graham Mercer, who was head of the Orthopaedic Department at the Repatriation Hospital spoke about the revitalisation of the Repat. A/Prof Tam addressed the gathering, thanking all who attended including retired members, past presidents, and of course the people who attended in support of their loved ones.

A/Prof Tam thanked in particular the past presidents who were there: Dr David King (1982–1983), Dr David Gill (1985–1986), Dr Peter Joseph (1988–1990) and Dr Philip Harding (1990–1992). He also acknowledged Dr David Cox, who was president of AMA(NT) in 2008.

He also recognised the new AMA(SA) life members, presenting certificates to those in attendance.

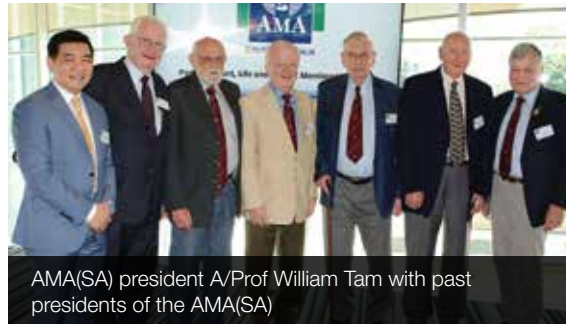
The AMA(SA)'s new life members' professional lives span psychiatry, general medicine, radiology, ENT, and health administration. The AMA(SA) is very glad to acknowledge them for their outstanding commitment to the Association, and the medical profession, over the past 50 years.

A/Prof Tam also thanked the many members who have supported the association over a professional lifetime, many through office bearer, council or committee roles, and others through the contribution of active and ongoing membership.

He also honoured the commitment of the AMA(SA)'s life members and retired members, saying that without them, the AMA(SA)'s efforts to keep governments accountable for a health system worthy of South Australians would be greatly diminished.

## Congratulations to AMA(SA)'s new life members

- Prof Robert Goldney
- Dr Peter Heysen
- Prof Brendon Kearney
- Dr Anthony Smith
- Dr John Tomich
- Dr Peter Charlton



AMA(SA) president A/Prof William Tam with past presidents of the AMA(SA)



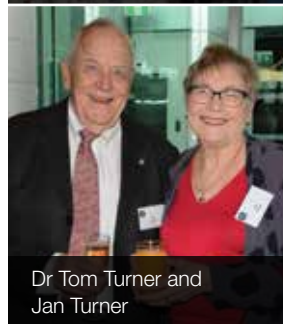
Dr John Tomich



Roberta Steele, Mary Crowhurst, Margie Harding



Dr Anthony Smith



Dr Tom Turner and Jan Turner



Jan Whitford



Prof Brendon Kearney



Dr Christopher Dibden, Dr David Hamilton, Dr Maurice Materne



Dr Peter Heysen



Peggie King, Dr David King, Dr John Crowhurst, Dr David Cox



Prof Robert Goldney



## AMA(SA) gets behind children's charity Backpacks 4 SA Kids

**B**ACKPACKS 4 SA Kids is a charity which provides children who are living in foster care with a backpack full of personal items to call their own.

The wonderful grass-roots charity was the recipient of a \$10,000 donation from the AMA(SA) Gala Dinner in May 2018.

In November, Backpacks 4 SA Kids did a shout out to the community as they were running low on a number of stock items for the children's backpacks.

AMA(SA), AMA Skills Training and sapmea staff all banded together and donated money from which we purchased a variety of clothes, books and journals for all requested age groups.

We hope that the donation of goods helps to make life a little brighter for some SA kids who are experiencing displacement.



*L-R: AMA(SA), AMA Skills Training and sapmea staff members Gail Hains, Natalie Brown, Claudia Baccanello, Eva O'Driscoll, Rosemary Mercorella, Kay Gallary and Joe Hooper with the items purchased in support of Backpacks 4 SA Kids.*

## AMA(SA) welcomes new membership engagement officer to the team

AMA(SA) is delighted to announce that our new membership engagement officer has commenced. We welcome Karen to the role and look forward to strengthening our contact with members of AMA(SA). She introduces herself below.

**M**Y name is Karen Flinn and I am your new membership and engagement officer for South Australia. I look forward to connecting with you all and meeting you at the AMA's upcoming events.

"I have been working within the health sector for almost 10 years specifically in management roles, ranging from recruitment, accreditation and operations to name a few. I also have extensive experience in medical deputising and managing small teams.

"These opportunities have allowed me to develop many skills and foster a love for the health domain.

"For those doctors considering joining the AMA(SA), please do not hesitate to contact me to discuss how we can best support you. Doctors who are current members, please contact me to discuss your membership or just to say hello!"

You can contact Karen on 8361 0108 or mobile 0407 789 499, and email [membership@amasa.org.au](mailto:membership@amasa.org.au).



# Working to eliminate the threat of nuclear war

**Dr Sue Wareham** is national president of the Medical Association for Prevention of War (MAPW). The AMA supports MAPW's ongoing work for a healthier, less violent planet, which Sue reports on here.



**H**AVING grown up in Adelaide and graduated from Adelaide University, it is always a pleasure for me to go back to this beautiful

city. Just recently, I had that pleasure again, although for a reason that is as far removed from good times as one could imagine – nuclear weapons. My visit was part of the education and awareness-raising about this pressing global health threat undertaken by MAPW and ICAN, the International Campaign to Abolish Nuclear Weapons.

This cause has consumed much of my time as a medical professional since graduation over 40 years ago. Our profession has played a huge role in addressing the threat. International Physicians for the Prevention of Nuclear War (of which MAPW is the Australian affiliate) was formed in 1980 to educate about the health impacts of these worst of all weapons and the need to abolish them. The organisation received the 1985 Nobel Peace Prize for its efforts. After complacency and lost opportunities globally at the end of the Cold War in 1991, interest and alarm at this threat hanging over humankind has increased again sharply in recent years.

The focus of the renewed momentum – in addition to ongoing and heightened risks – has been a resurgence of the health message, with medical professionals in Australia taking the lead. The message is simple: that in the event of any use of nuclear weapons, the human consequences will be catastrophic, and there is very little that our profession will have to offer the survivors. Even a 'small' nuclear war would be likely to affect global climate, causing blocking of sunlight and widespread famine. The only responsible approach is prevention, and the only way to ensure that is to eliminate the weapons.

In 2007, a very small group in Melbourne, primarily members of MAPW, initiated



ICAN, the International Campaign to Abolish Nuclear Weapons. The movement rapidly spread to become a strong global campaign which now has nearly 500 partner organisations in over 100 countries. ICAN's specific purpose was, and remains, to stigmatise, prohibit and eliminate all nuclear weapons. The challenges are monumental and obvious, but enormous progress has been made and momentum built.

ICAN works consistently and effectively with supportive governments as well as partner organisations. In 2013 and 2014, a series of three large conferences were held to examine the evidence on the humanitarian impacts of nuclear weapons, in Norway, Mexico and Austria. The Vienna conference in December 2014 concluded that nuclear weapons threaten "... profound and long-term damage to the environment, climate, human health and wellbeing, socio-economic development, social order and could even threaten the survival of humankind."

Conclusions such as these led directly to UN negotiations in 2017 for a prohibition treaty: the Treaty on the Prohibition of Nuclear Weapons, commonly called the nuclear weapons ban treaty. It was adopted by a strong majority of UN

member states on 7 July, 2017. Its purpose is to stigmatise and delegitimise the weapons, and to reassert the health and humanitarian imperatives over and above dangerous military strategies. Both chemical and biological weapons, neither of which pose the same existential risk to civilisation as that posed by nuclear weapons, are prohibited under international law, as are landmines and cluster munitions.

The ban treaty prohibits not only all nuclear weapons but all activities associated with them – their development, testing, production, possession, use and threat of use. Significantly for Australia, the treaty also prohibits all activities that encourage or assist the policies of the nuclear-armed states. The Australian Government has indicated its opposition to signing and has refused to state that nuclear weapons must never be used again. The treaty will come into effect when 50 countries have signed and ratified it, and progress thus far is on a par with or faster than that of other treaties which have become fundamental parts of international law, such as the Non-Proliferation Treaty and the treaties prohibiting chemical and biological weapons.

The ban treaty would not have come about without civil society pushing the agenda along. ICAN played a pivotal role and was awarded the 2017 Nobel Peace Prize in recognition of its ground-breaking efforts. Other civil society organisations, particularly the International Red Cross and Red Crescent movement, also played critical roles. In 2011, the organisation's Council of Delegates emphasised "the incalculable human suffering" that any use of nuclear weapons would cause, and "the lack of any adequate humanitarian response capacity", and urged the prohibition and complete elimination of all nuclear weapons. In November 2017 the movement called on all states to promptly sign and ratify the new ban treaty.

Collaboration between health care professionals has been strong. In welcoming the new prohibition treaty last year, a joint statement in September 2017 by International Physicians for the Prevention of Nuclear War, the World Medical Association, the International Council of Nurses, and the World Federation of Public Health Associations affirmed the medical evidence:

"Nuclear weapons violate international law because they are inevitably indiscriminate and disproportionate in their effects... Even a small fraction of the nuclear weapons that exist today can damage the global climate and food production so severely that billions of people would starve."

The statement urged all governments to sign and ratify the ban treaty. On 9 October this year, a World Medical Association declaration reaffirmed its commitment to this issue and requested the following:

"... that all National Medical Associations ... use available educational resources to educate the general public and to urge their respective governments to work urgently to prohibit and eliminate nuclear weapons, including by joining and implementing the UN Treaty on the Prohibition of Nuclear Weapons."

In Australia, MAPW has initiated a health professionals' statement urging Australia's support for the ban treaty. Its endorsement by AMA members and medical students – either as individuals or organisations – would be extremely welcome. Flinders Medical Students' Society has led the way in signing on.

Leading medical journals continue their advocacy also. On 9 May this year, the *New England Journal of Medicine* published a renewed call to action for the medical community, 'The 2017 Nobel Peace Prize and the Doomsday Clock – the end of nuclear weapons or the end of us?', which was co-authored by Melbourne physician and ICAN founding chair A/Prof Tilman Ruff. The article's title drew attention to the Bulletin of the Atomic Scientists' Doomsday Clock, which has warned of our nuclear peril since 1947. In January 2018 the clock's hands were advanced to two minutes to midnight, the closest they have been to global nuclear catastrophe since 1953. The article concluded:

"ICAN's Nobel Peace Prize is a step toward mobilizing citizens worldwide to help ensure that humanity survives the existential threat posed by nuclear weapons. The Treaty on the Prohibition of Nuclear Weapons lights a path that all countries can take. The stakes could not be higher."

The voice of medical doctors speaking out for the elimination of the worst of all weapons of mass destruction – through explicit policy statements, education and political advocacy – is needed now as much as ever. The Treaty on the Prohibition of Nuclear Weapons offers the most promising progress towards this goal that we have seen for decades. There are huge challenges ahead, but this opportunity must not be lost.

*Dr Sue Wareham OAM graduated from medicine at the University of Adelaide in 1975 and has worked in Canberra as a GP. She is national president of MAPW, and is on the Australian board of ICAN and of International Physicians for the Prevention of Nuclear War. She has retired from general practice but her work for a healthier less violent planet continues. She can be contacted at [warehams@ozemail.com.au](mailto:warehams@ozemail.com.au).*

*To endorse MAPW's statement on the issue, go to: [mapw.org.au/news/please-support-our-call-for-australia-to-sign-the-nuclear-weapons-ban-treaty/](http://mapw.org.au/news/please-support-our-call-for-australia-to-sign-the-nuclear-weapons-ban-treaty/)*

## Who has nuclear weapons?

United States .....	6,800 warheads
Russia .....	7,000 warheads
United Kingdom .....	215 warheads
France .....	300 warheads
China .....	270 warheads
India .....	110 – 120 warheads
Pakistan .....	120 – 130 warheads
Israel .....	80 warheads
North Korea .....	< 10 warheads
<b>Total .....</b>	<b>14,900 warheads</b>

Source: Federation of American Scientists 2017

### NATO nuclear sharing

In addition, five European countries have US nuclear weapons on their soil: Belgium, Germany, Italy, Netherlands, Turkey

### Weapons on high alert

The United States and Russia still maintain roughly 1,800 of their nuclear weapons on high-alert status, ready to be launched within minutes of a warning – either accurate or false – of attack.

### 'Accidental' nuclear war

- 2014 study by Chatham House in the UK 'Too close for comfort'
- 13 instances since the 1962 Cuban Missile Crisis when nuclear weapons were nearly used
- "Individual decision-making, often in disobedience of protocol and political guidelines, has on several occasions saved the day"

### Economic cost of nuclear weapons programs globally

Over \$100 billion annually



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**Adelaide Community Healthcare Alliance Incorporated (ACHA)** is the largest private hospital group in South Australia, comprising Ashford Hospital, Flinders Private Hospital and The Memorial Hospital.

# Inside the AMA: a medical student's view

Earlier this year, final-year Flinders medical student **Riche Mohan** spent a six-week placement with the medical practice team at federal AMA in Canberra. Here is his story.

I chose this placement to gain some insight into what the AMA does and how it is done. While there, I was able to see first-hand how advocacy happens, and meet the people working behind the scenes to pull it all together.

From day one of medical school, we all begin to form an idea of what the AMA does, and for some, this impression doesn't evolve beyond a subscription with some perks. My time with the AMA helped me understand why it is so important for both doctors and patients, and I hope to share my experience to spread this understanding.

During my placement, I met with directors and policy advisors, and was interested by the scope and breadth of their portfolios, as well as their ability to mobilise on any given topic depending on the priorities of the day.

The 24-hour news cycle brought a new issue to the front pages of newspapers around Australia and the AMA was often called to inform debate. Some of the hot topics during my placement included the appropriate timing of vaccinations, out-of-pocket expenses for privately insured patients and mandatory reporting legislation for doctors. All these issues required evidence-based, honest responses delivered in a manner which would not betray the trust of doctors or the public.

Meanwhile, government, private health insurers, hospitals stakeholders and doctor and patient advocates are continuously formulating and debating policy which can change the way health care is delivered in Australia today and years from now. The challenge was in ensuring that any changes would continue to empower excellent doctors to provide excellent patient care.

I learned that this is a key difference between the AMA and other organisations. The AMA is not just looking to improve working conditions for doctors as a union might, but instead looks to service the needs of

its members and the people they serve – the patient. This is highlighted by the AMA Code of Ethics, hung on every office wall, which states: "Consider first the wellbeing of the patient".

This would not take place if it weren't for the countless hours of hard work by both AMA staff and volunteer doctors around Australia who sit on the various councils and committees. The policy direction decided on at these meetings informs position statements and media releases, the potency of which should not be underestimated, as they form the basis of high-level discussions which can result in real outcomes nationally.

“From day one of medical school, we all begin to form an idea of what the AMA does, and for some, this impression doesn't evolve beyond a subscription with some perks. My time with the AMA helped me understand why it is so important for both doctors and patients...”

I came to realise that there are competing forces out there trying to fundamentally change how medicine is practiced and delivered in Australia, and that, without diligent oversight, we are all at risk of being part of broken system.

The focus of my time at the AMA was to examine the evidence behind quality- and safety-based hospital funding. The Independent Pricing Authority, in conjunction with the Commission for Safety and Quality in Healthcare (directed by COAG), has been tasked with implementing measures which will see hospitals being penalised with funding deductions for adverse events. These include sentinel events,



hospital-acquired complications and avoidable readmissions. Though introduced to achieve quality and safety improvements, evidence from around the world suggests that such penalties do not lead to long-term outcome improvements. Instead, they ask that hospitals improve their standards, despite reduced funding.

The big take away for me was that those at the beginning of their careers, such as students and junior doctors, have the most to gain or lose by the decisions being made today. Though our learning and careers often become all consuming, it is important to stay engaged with these issues and support those acting on our behalf – particularly if we cannot participate ourselves.

My placement allowed me to see first-hand how advocacy issues are raised, dissected, discussed and actioned and I gained an appreciation for the influence the AMA has – an influence we should support and guide through our participation.

*Riche Mohan is now an intern at Flinders Medical Centre. He can be contacted at [moha0302@flinders.edu.au](mailto:moha0302@flinders.edu.au).*



# Creating healthy cities: the role of green open space in a changing urban environment

**Beth Keough** and **Claudia Galicki** report on the challenge of protecting and promoting a healthy urban life.

FOR some time now we have commonly understood that increased urban density is good for human health and wellbeing; it creates more vibrant and sustainable city environments, stimulates physical and social activity and preserves valuable rural horticultural and native areas. However, with a more compact urban form comes the challenge of protecting and promoting certain aspects of healthy urban life. For example, the provision and quality of both private and public green open spaces.

As Greater Adelaide continues to grow and develop, in particular through urban infill, including medium and high-density development, there will be added pressure on green space if growth is not well planned and managed. The 30-Year Plan for Greater Adelaide<sup>1</sup> has a target of increasing urban green cover by 20% in metropolitan Adelaide by 2045, in recognition of the important role trees and green spaces play in creating healthy cities. The way we live is changing. Apartment living, small lot housing and increased urban density offer more housing choice, which reflects population trends and changing lifestyle demands.

Increasingly, we are seeing smaller residential allotment sizes with limited greening and sites covered by largely impermeable surfaces. Consequently, tree and shrub canopy and general green space are in decline across our city and suburbs, and this is a trend being experienced across most of Australia. Adelaide's tree coverage is, in fact, now amongst the lowest of the capital cities, at 27% - less than half of Hobart's, which is highest at 59%<sup>2</sup>.

There is compelling evidence that spending time in nature has strong benefits for both physical and mental health. The 2016 World Health Organization review *Urban Green*



*Spaces and Health: a Review of the Evidence*<sup>3</sup> outlined these benefits, such as:

- Reductions in depression, anxiety and stress in men and women
- Improved mental health for children
- Reduced cardiovascular disease
- Reduced risk of diabetes
- Better pregnancy outcomes
- Reduced mortality

Other health benefits of green space outlined in the WHO (2016) report, include improved relaxation and restoration, improved air quality, improved social capital, improved functioning of the immune system, improved physical activity, noise buffering, and reduction of heat in cities.

Green spaces support species biodiversity of birds, bats, bees and plants. Urban greening has also been found to enhance sense of safety in urban neighbourhoods.

In addition, there are equity implications of quality green public spaces, where those living in the most affluent areas,

have greater access to green space and its benefits. Adelaide has the least equitable distribution of green space and green cover of all capital cities with 20% of land covered by green space in the most affluent areas compared to 12% in the least affluent areas<sup>4</sup>. There is accumulating evidence showing that disadvantaged groups tend to benefit the most from improved access to urban green space<sup>5</sup>.

Green spaces and density can both be good for health and wellbeing when done well, however when urban infill development is not well planned and managed, it poses a major risk to our vital green infrastructure. Increased greening in streetscapes and public open space will become more and more vital as urban landscapes change, and the role of trees is particularly critical. Trees are the "powerhouses" in the greening hierarchy, providing health, social, environmental and economic benefits that other forms of greening cannot deliver in isolation.

The solutions are not simple however, and we know that maintaining public parks is costly. Poorly managed and



maintained green spaces can also deter members of the community, for example dangerous trees interfering with sporting or social activities or leaf litter looking unappealing and blocking household gutters.

A diverse range of disciplines and policy workers, including but not limited to urban planners, need to work together to better protect and promote our green spaces and share the evidence at a policy, service delivery and community level to support integrated action.

Building on a strong and formal health and environment sector partnership, Healthy Parks Healthy People SA is focused on enhancing understandings of the value of embedding nature-based solutions for the health and wellbeing benefits they produce. Some outputs of the program to date include ensuring that health and environment priorities are reflected in the state's new planning system and the 5 Ways to Wellbeing in Nature promotional campaign which provides some easy ideas for getting a regular nature dose that can have big

benefits for physical, social and mental health and wellbeing.

**“Green spaces and density can both be good for health and wellbeing when done well, however when urban infill development is not well planned and managed, it poses a major risk to our vital green infrastructure.”**

So, consider writing a ‘nature’ prescription for the next patient that walks through your door, knowing it will help their mental and physical health and wellbeing, and remind them to value and protect their local green spaces, like the tree in their backyard or their local pocket park.

*Beth Keough and Claudia Galicki are senior project officers in the Prevention and Population Health Branch, Department for Health and Wellbeing.*

#### References:

- 1 Government of South Australia, Department of Planning, Transport and Infrastructure 2017, *The 30-Year Plan for Greater Adelaide 2017 Update*, [http://livingadelaide.sa.gov.au/\\_\\_data/assets/pdf\\_file/0003/319809/The\\_30-Year\\_Plan\\_for\\_Greater\\_Adelaide.pdf](http://livingadelaide.sa.gov.au/__data/assets/pdf_file/0003/319809/The_30-Year_Plan_for_Greater_Adelaide.pdf)
- 2 RMIT, 2017. *Where Should All The Trees Go? Report*. [ONLINE] Available at: <http://202020vision.com.au/help-hub/the-research-hub/detail/?id=4059>.
- 3 WHO Regional Office for Europe, 2016. *Urban green spaces and health*. Copenhagen.
- 4 Astell-Burt, T., et al. (2014). “Do low-income neighbourhoods have the least green space? A cross-sectional study of Australia’s most populous cities.” *BMC Public Health* 14(1): 1.
- 5 Mitchell RJ, Richardson EA, Shortt NK, Pearce JR (2015) Neighborhood environments and socio-economic inequalities in mental well-being. *AM J Prev Med* 49:80-84.



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# AMA(SA) and Law Society Medico Legal Dinner

**O**N Friday 2 November, the AMA(SA) and the Law Society of SA hosted the annual joint dinner and debate for 70 doctors and lawyers at the Playford Hotel on North Terrace.

AMA(SA) president A/Prof William Tam introduced the evening.

“We greatly value our links and work together – between the AMA and the Law Society and between ourselves as doctors and lawyers,” A/Prof Tam said.

“We can have our serious talks about the big issues where medicine and the law intersect. But it is good to leaven these with events such as this, where we can break bread, share drinks, and enjoy great conversation and great company.”

The topic of debate for the evening was ‘Doctors have more to gain than lawyers from artificial intelligence’.

The debate speakers were Prof Guy Maddern, hepatobiliary surgeon, and RP Jepson professor of surgery at the University of Adelaide and Brian Austin, a well-known barrister practising at the Independent Bar principally in South Australia.

Without a doubt, Prof Maddern won the debate on behalf of the medical profession! A great night was had by all.



A/Prof William Tam, and Prof Guy Maddern



Joe Hooper, CE AMA(SA), Dr David Walsh, Council Chair, Dr Trevor Mudge, Inaugural Board Chair



Prof Guy Maddern and the attendees



Brian Austin



A/Prof William Tam, AMA(SA) President and Tony Rossi, Past President, Law Society



Attendees enjoying the dinner





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# Three generations of doctors: the Harris family

Dr Richard ‘Harry’ Harris, who was recently named 2019 SA Australian of the Year, became a household name for his efforts during the Thai cave rescue earlier this year. But did you know that his father almost drowned as a small boy? Or that he comes from a line of esteemed medicos?

**T**HROUGH water-filled culvert – little boy’s remarkable escape’ – this was the headline in the local newspaper when little Jimmy Harris, aged three, was sucked through a concrete pipe culvert carrying a full stream of irrigation water. The little boy was unconscious when recovered, but was resuscitated and suffered no long-term ill effects.

“It is remarkable that the boy should have recovered so quickly, for it is estimated that he was out of sight for some 10 minutes,” the newspaper said. “There was only a very small clearance above the water in the pipe.”

So, in that stranger-than-fiction way that life sometimes has, little Jimmy grew up to become Dr James Harris, father of Adelaide anaesthetist Richard Harris, who made world headlines for his underwater rescue work in a flooded Thai cave system.

By a sad coincidence, Jim was dying in Adelaide while Richard played his part in the rescue of the Thai boys’ soccer team and their coach, whose quick visit to a cave system at Chiang Rai turned into a potential death sentence and led to an epic international rescue mission.

Richard is a doctor’s son of a doctor’s son. His father Jim, who became a leading vascular surgeon in Adelaide, was born to Dr George and Jessie Harris.

George was a medical practitioner in Renmark, where he cared for the health of a community of 5,000, people from 1925 until 1945, when he died of a heart failure at age 47.

“Renmark was fortunate to have had a doctor of such high professional attainments for so long,” said the *Murray Pioneer* in his obituary.

“The exceptionally fine service which he had rendered to local residents during the years and the capable manner in which he had for considerable periods, and more especially in the war years, borne two men’s responsibilities, found a ready response in the hearts of the



people, and the high esteem in which he was held was apparent from the widespread expressions of regret at his passing and the striking tributes paid to him.”

Born in Sydney in 1898, George was the elder son of the late Mr and Mrs John Harris, of England, his father having come out to Australia as a naval engineer. He was educated at St. Peter’s College, Adelaide, and the Adelaide University, graduating MB BS in 1923.

George offered his services on the front line in World War 2 and was on the Army Medical Corps reserve list, having been called up for duties in the metropolitan area on several occasions.

George was a keen sportsman, and served on the committees of the Renmark Golf Club and Tintra Tennis Club, and would have been appointed president of the tennis club on the day before his death but for the annual meeting having been postponed because of the rain.

His funeral was one of the most largely attended ever seen in Renmark.

His brother John – also a doctor – served the Lock 7 community, River Murray from 1931 till 1934, then moved to the Hawker area before acquiring a practice at Kiama near Sydney.

George’s son Jim was also an outstanding sportsman, and a boarder at St Peter’s College, where he played for the first teams in football and cricket.

He studied medicine and was resident at the Royal Adelaide Hospital and the Adelaide Children’s Hospital.

Keen on surgery, he took the usual path at the time, of obtaining a ship’s surgeon position on a passenger ship and in 1955 headed to the UK for postgraduate study.

There, he quickly passed his primary examination and then joined Birmingham Accident Hospital before becoming a resident surgical officer at the Warneford Hospital in Leamington Spa, Warwickshire.



That was a highly sought-after position under Geoffrey Taylor and Christopher Savage and was usually filled by an Australian. When one Australian left the role, Taylor would say "Get me another of you" – and nobody ever let him down.

Taylor and Savage were excellent surgical technicians with the latter having a large interest in vascular surgery and surgical teaching, having just come from St Thomas' Hospital London.

It was from this post that Jim passed his fellowship of the Royal College of Surgeons of England.

While in England, he had met Marion Taylor and they married in 1959. Daughter Amanda was born there, while Kristina and Richard were born in Adelaide.

They returned to Adelaide in 1961, and Jim joined the Queen Elizabeth Hospital as senior lecturer in surgery under Professor Dick Jepson.

Here, his abilities were recognised and after a few years he obtained a position with Professor Jack Wiley, in San Francisco, to further his expertise in major vascular surgery.

When he returned to Adelaide in 1968, Jepson, who was retiring to enter private practice, invited Jim to join him.

It was Jepson's view that one's best academic work was done by the age of 40. Jim, 39, agreed.

Together they set up one of the leading clinics in general surgery, with a heavy leaning toward vascular surgery.

Jim was a member of the Renal Transplant Team at the Queen Elizabeth Hospital.

Aside from his abilities as a surgeon, he had the knack of getting on with everyone he met. He was a friend of the gatekeeper at the QEH and fished with him. He was a fellow bird lover with a mortuary attendant.

These were among his many interests outside medicine. He was on the board of the Adelaide Zoo and, through his love of birds, he became a leading member of the Adelaide Ornithologists' Club. In sport, he turned to golf, tennis, and as an owner of racehorses.

Most of all he loved fishing, from Kangaroo Island to Coffin Bay. On his last fishing trip, he was having no success until a friend cried out "Jim, Jim you've got one!"

His rod was bent over and he leapt up and reeled it in, only to find that his devoted friends had tied a packet of frozen whiting fillets to his line. Fishing-wise, he could now die happy.

Jim is survived by children Amanda, Kristina and Richard, nine grandchildren and three great-grandchildren.

Jim lived to learn of Richard's heroics attracting worldwide attention and fame, but sadly died while the rescue was still in progress and before the subsequent announcement of his award of the Star of Courage and Order of Australia Medal.

By a sad coincidence, Jim was dying in Adelaide while Richard played his part in the rescue of the Thai boys' soccer team and their coach, whose quick visit to a cave system at Chiang Rai turned into a potential death sentence and led to an epic international rescue mission.

Four months later, while trying to return to normal life as an Adelaide anaesthetist, Richard remains in demand to speak about the remarkable medical and other aspects of the cave rescue. In recent weeks he has given a presentation to his anaesthetic colleagues in Adelaide, and been a well-received guest speaker at the Australian Barristers Association national conference in Sydney.

*This article was compiled by Heather Millar with the help of Helen Stagg, historian and author of Harnessing the River Murray: stories of the people who built Locks 1 to 9, 1915-1935 (published 2015), historybyhelen.com.au. It also draws on the Advertiser's obituary of Dr Jim Harris, published on 8 September 2018.*



Courtesy Renmark Branch, National Trust

## THROUGH WATER - FILLED

### CULVERT

### Little Boy's Remarkable Escape

#### Renmark Doctor's Son

A remarkable escape from death by drowning occurred at the Tintara Tennis Courts last Thursday, when little Jimmy Harris, aged 3, youngest son of Dr. G. D. Harris of Renmark, was sucked through a concrete pipe culvert carrying a full stream of irrigation water.

Attracted to the channel by Jimmy's disappearance, a number of women players, including Mrs. Harris, made efforts to find trace of boy and fearing the worst some of them waded knee deep into the flowing water in the hope of locating the body.

Answering the women's calls, the men also joined in the search, and the possibility the boy having been drawn into the culvert where Twenty-eighth street crosses the channel drew a number there.

Eventually the mother saw the body of her son appear at the down stream opening, and rushing in she dragged him ashore. The boy was unconscious when recovered, but resuscitation methods applied by the menfolk were quickly rewarded with success, and, to the great relief of all present, Jimmy commenced to whimper and soon regained strength. He showed little ill effects by next day.

It is remarkable that the boy should have recovered so quickly, for it is estimated that he was out of sight for some ten minutes. There was only a very small clearance above the water in the pipe.

# Audi A5 Sportback Quattro

What is midnight blue, has a four-wheel-drive system which evokes rallying and has nothing to do with supermarkets? That would be the Audi A5 FSTI Sportback. A bumper car for the bumper edition. *medicSA's* motoring enthusiasts **Dr Philip Harding** and **Dr Robert Menz** report.

**ROBERT:** Hey Phil, did you know when Audi first introduced the A5 11 years ago, it was only available as a two-door coupe? I thought it was the prettiest full-sized Audi ever.

The two-door coupe is still available and since 2009 there has also been a cabriolet (soft top which replaced the A4 cabriolet) and sport back available. These share a platform with the A4 sedan derived from the Volkswagen MLB architecture. I was initially dismissive of the 5 door, but after nearly a week behind the wheel, I have come to appreciate it much more – in fact, I now really like it.

And the Quattro name? It sounds more Italian than German and has been used by Audi since 1984 for its four-wheel-drive vehicles. The original Audi Quattro was based on an Audi 80 (predecessor to the A4) and was powered by a 2.1 L turbocharged five cylinder in-line engine. It revolutionised rally driving with unbeatable handling. While researching this article I did come across some live rally action <https://www.youtube.com/watch?v=cDRkHXMhQFo>

And the supermarket connection? None at all apart from being both four-lettered German brands, although I understand that there is an Aldi supermarket and Audi showroom adjacent to each other in Melbourne.

The A5 is a fine-looking machine with its long, sloping boot and frameless windows. We were lucky enough to test the top of the range A5 FSTI Quattro. Also available are the significantly cheaper 7-speed automatic front-drive versions with either 2 L petrol or diesel, both of which are rated at 140kW. The Quattro has the same sized motor retuned to

produce 185 kW and 370 Nm, which slingshots this Q car from 0 to 100 km/h in six seconds. I remember, as a medical student in the 1970s, one of my classmates took me for a ride in his father's lairy yellow GTHO Falcon (then the fastest four-door production car in the world) which clocked acceleration from 0-100 in 6.5 seconds, highly impressive then, but not able to match the exhilarating figures of this classy hatchback.

As you will expect from cars of this calibre, the A5 is brimming with safety-features



and other electronic gadgetry. Some of the features I really enjoyed include the multi-adjustable heated leather electric seats, with an extension option in the squab for people with long femurs; the fabulous electronic dash board which can be adapted for almost any display you want and is particularly helpful with navigation; projection of the Audi 4 ringed emblem onto the road underneath the door at night; and the induction iPhone charging pad in the centre console. Some of my friends did not believe you can recharge your phone without a cable. If

you happen to forget your phone is there when you leave the car, a voice tells you that you have left your phone in your car, and for the hearing challenged, the same message comes up on the dash screen. Not everyone, me included, is a fan of the iPod-sized screen jutting up in the middle of the dashboard, especially when the same information is available on the main digital dash. Sophisticated driving guides abound and include adaptive cruise control, lane and blind-spot warning lights, and an excellent cruise control which applies the brakes to maintain speed – very handy on long

hills like Willunga. Golfers are well catered for with a large boot and power tailgate. There are also some handy straps to restrain small items like wine bottles and stop them from rolling around in the boot. The A5 is particularly fun at night with adjustable mood lighting which changes colour from reds and greens to purples and blue. And the sunroof also has a fly-screen.

So Phil: How did you enjoy the drive?

**Phil:** Well, you've said it all about the features. My A3 Cabriolet from a few years ago also had this 2L FSTI engine and I always thought it deserved Quattro, but that was only available in the hardtop.

My A3 performed very well once moving, but from a standing start, applying full power to the front wheels was impossible without spinning them – not a problem with this A5 Q. I too was sceptical about the central screen, although reluctant to be critical without becoming fully conversant with it.

Otherwise the electronics are great – as you know, I'm a cruise-control freak and this one's particularly good. Coming down the freeway, it held the speed at 90 without deviating more than 1 km/h – very useful with all those cameras around. It also incorporates a limiter function,



something I've only encountered in each of the two Mercedes Benz I've owned, and particularly useful in this vehicle if you want to exercise it around town without exceeding the speed limit. I'd be interested in hearing your impressions of its ability to go round corners seemingly without any limit, with regard to rate of turn, while staying quite flat and feeling very secure.

**Robert:** For me the multi-adjustable seats certainly allowed an ideal set up. There are five driving modes designated: Comfort, Dynamic, Individual, Auto and Efficiency, which are self-explanatory.

The overall impression is one of quiet sophistication. The luxury leather and adequate rear seat legroom facilitates comfortable cruising for four, and it would be very easy to simply drive sedately around the suburbs. However, when I asked the serious question, the A5 as mentioned above has more than enough acceleration combined with superb handling and great brakes, which means it can be readily hassled rapidly through the twisty bits in the Adelaide hills like a real sports car.

My driving companion for one day was a proper car enthusiast (he won Concours at this year's Bay to Birdwood) and was highly impressed with most aspects of this machine, although he would have gladly removed the central screen. We managed to find some great roads around Scotts Creek and Mylor before a freeway



trip back to Stirling, and enjoying excellent coffee at Miss Perez. Freeway cruising was quiet, the optional Bang and Olufsen sound system appropriately amplifying Art Blakey's Jazz Messengers, the odometer reading less than 2000 rpm, and instant economy reading 5.2 L /100 km.

**Phil:** My driving companion would freely admit to being more interested in the colour, which we both thought very elegant, as was the overall design inside and out. Our route was remarkably similar to yours, taking advantage of the necessity to visit a tree nursery at Cherry Gardens, then more twisty roads on the back way to Stirling where the only difference was that coffee was at Red Cacao before the 90 km/h cruise back to town. It seems that we are unanimous about the centre screen – at one stage, I had it displaying navigation,

while I had my telephone system on the main dash, without really understanding how I achieved that. All well and good perhaps, but really too much information and – importantly – increased potential for distraction which is not good for safety.

Overall, however, a very big tick from both of us.

The test car was provided by Solitaire Motors and in standard form has a drive-away price of \$89,203, although this particular version had nearly \$20,000 of options. Of course, AMA member benefits include a substantial discount which more than covers your cost of membership.

*Phil Harding is a former AMA state president, editor of medicSA, and former owner of an Audi A3 Cabriolet.*

*Robert Menz is a GP who once owned an Audi Fox.*



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# Whither history? – and a Jolly good story

It is no exaggeration to say that the recording and safeguarding of medical history and heritage in South Australia is at a crisis point, writes **Dr Philip Harding**.

**T**HERE are a number of organisations – stakeholders, perhaps, in modern parlance – with an interest in the subject: notably the SA Medical Heritage Society (SAMHS), the RAH Heritage Office and Committee, and the AMA(SA) itself, as noted on page 56-57 of this issue.

Additionally, other teaching hospitals, groups associated with other health professions, and doubtless some individuals, have collections of valuable documents and artefacts; and it's not all about old instruments and pictures, there are stories to be told and made available to the public about the achievements and contributions to knowledge in the health field of countless South Australians over many generations. This cannot be achieved by a scattered collection of memorabilia under multiple stewardship.

For some years now there has been, amongst the organisations mentioned above, a perception of the need for a central repository where such material might be stored and displayed, called a Health or Medical Museum or some such suitable title. SAMHS has had internal discussion and has submitted a proposal to government, but it received no support. Likewise the RAH Committee has made a similar approach more recently, but no action has yet occurred.

AMA(SA) strongly supports the Museum concept. 'Lot 14', as the old RAH site is now called, seems an attractive location although other possibilities exist. There are museums in SA for various aspects of our history and culture – general, maritime, aviation, trams, immigration, to name

an obvious few. The stakeholders should join forces and present a unified view to promote health as being deserving of joining the list.

A major factor in this matter coming to crisis point is, as noted in my Editor's Letter in this issue, the lack of a plan for the long-term future of the material from the old RAH. Despite the great work done by the hospital's Heritage Office in

of her father Sir Trent de Crespigny, which was languishing in a side room off the hospital library following the government's disestablishment of the IMVS of which he was essentially the founder.

An AMA(SA) proposal was put to and initially supported by then Health Minister Snelling that the portrait should adorn the entrance to the

pathology laboratories at the nRAH which would bear his name. Further negotiation on this and other naming proposals were fruitless. Finally Charlotte, with the help of an anonymous senior physician, simply uplifted the portrait and relocated it to the Art Gallery of South Australia, which restored it and where it has been hung with a plaque describing his many achievements and contributions to medicine.

The RAH Registered Nurses Association decided that something needed to be done about the beautiful Cedar Prest stained glass window from the hospital chapel – originally funded by the nursing and medical staff and dedicated at the Foundation Day service in 1982 – and as a result of persistent lobbying and refusal to take no for an answer have now arranged for it to be displayed in a prominent position at the nRAH.

The Foundation Day Service and associated William Wyett oration and emeritus staff gathering, an important day in the RAH calendar for countless decades, has not been held since 2013.

Finally, an enterprising group of RAH resident medical staff have collaborated with the West Oaks Hotel in Hindley Street to re-establish the Jolly Bar, which was their social gathering point



preservation and off-site storage, there has been anxiety that things might be lost or forgotten. Three stories, all with a good outcome, reflect the concern felt by staff or others connected with the RAH during the period it was being wound down.

In about 2013 Prof Charlotte de Crespigny became concerned about the condition of the Ivor Hele portrait

at the old hospital. They salvaged the honour boards of past presidents of the RMOs Association and recipients of the Mark Jolly Travelling Fellowship, which bear the names of many present-day senior consultants, together with other memorabilia, and set them up in an upstairs room of the hotel which has already been used for medical school reunions and the like. In the words of hotelier Hugo Pedler:

*“At the old RAH, the doctors had their own private bar to wind down and debrief after gruelling shifts and all kinds of amazing work. Named for a legendary member of the medical community, Mark Jolly, it had been open since 1974. Now with the hospital moving to the west of the CBD, we’ve been working with medical staff to carry the tradition forward and create the all-new Jolly Bar. This time the bar will be open to all, as well as keeping the culture and traditions of some of our state’s best doctors, as they find a new place to call home at the end of a shift or at the weekend.”*



On a recent Friday evening, the bar was full of final-year students awaiting the start of the AMSS awards function at the end of their course, in a very happy atmosphere.

These three stories illustrate what can be achieved by dedicated individuals or small groups with a cause to pursue. Time now perhaps for some corporate action.

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# Your life, your story

medicSA's managing editor **Heather Millar** also works as a volunteer with palliative care patients to record their memoirs. Here she explores the benefits of telling your life story.



**I** was shortly before my father died that I recorded his memoirs and made them into a book. Difficult though the process was, it

ignited something in me. I went on to volunteer in the Biography Program at Calvary's Mary Potter Hospice, recording the stories of people in palliative care.

I have witnessed firsthand the value people get from reviewing their life in this way. I have seen them light up as they relate their stories. It seems to be a process of making sense of one's life – was it a good one? Did I do it well? Did I live it fully? Was it worth something, in the end? Recording their story and having it written down leaves behind evidence that they existed and that perhaps their life was meaningful in some way.

My father jotted his stories down in spidery handwriting on the back of a pile of used envelopes. It was quite a towering stack by the time we got around to recording them. Having lived on his own for the last years of his life after my mother died, this act of recording his memories gave him a reason to get up in the morning – a sense of purpose.

Purpose has in fact been found to be a defining feature in mental health. Researchers from the Rush Alzheimer's Disease Center in Chicago tracked 1000 people over seven years, with the average age of around 80. They found that people who had a high level of purpose were more than twice as likely to remain free from Alzheimers, had 30% less cognitive decline and half the mortality rate. They also found a strong sense of purpose created more satisfaction and happiness, better physical functioning, and better sleep.

But why wait until people are palliative? Perhaps this kind of life examination through the process of self-reflection can add value throughout our lives?



There are certainly health benefits – albeit anecdotal – according to biographers who work in the area. Paul English is a videographer of life stories, and president of Life Stories Australia, a professional association of personal historians.

**I have witnessed firsthand the value people get from reviewing their life in this way. I have seen them light up as they relate their stories. It seems to be a process of making sense of one's life – was it a good one?**

"Telling your story can help validate your life, career and achievements," says Paul. "Not only can it be tremendously cathartic and help to lift mood, but also serve as a wonderful way of connecting the generations, acting as a sort of conversation starter between grandparent and grandchild.

"Even documenting a person's career as they come to retirement can be tremendously worthwhile and provide a transition into the next stage of their life. We've done life story videos for people as young as 50 and 60 and all the way into their 90s."

When people pass away, so often their stories die with them. The older I have become, the more I want to know about my grandparents and great-grandparents and how they lived.

In another study, a team of psychologists from Emory University in Atlanta, USA, measured children's resilience and found that those who knew the most about their family history were best able to handle stress, had a stronger sense of control over their lives and higher self-esteem. The reason: these children had a stronger sense of 'intergenerational self' – ie, they understood that they belonged to something bigger than themselves.

I have spent the last few years researching my family tree. I have learned about ancestors I barely knew



existed, and I have learned their stories – because someone wrote them down. I have learned about the boy from Scotland – my great-great grandfather on my father’s side – who was sent to Australia as an ‘apprentice’ – a term they used for the youngest convict boys. I learned about the 13 children he had, and how he and his sons were some of the original foresters of South Australia. I learned about the 16-year-old girl from Tipperary and her husband who were sent to India with the British Army. And how, at 21, she ‘sat down to dinner one Sunday, and by the next, they were all gone’ – her husband and two baby boys had contracted the plague and died very suddenly. She went on to marry her husband’s best friend – my great-great grandfather on my mother’s side – and started a new family, so she didn’t have to return to Ireland, where the Potato Famine was ravaging the country. I also learned about the line of newspaper-men I am descended from, that I didn’t



know existed until just before my mother died.

Their stories make me understand myself more, my history, my impulses, my talents. I feel connected to something greater ... I feel connected to their stories, and to my own

ancestral line. The truth is ... I feel less alone in the world, knowing where I come from.

*Heather Millar is a writer, editor and ghostwriter. For more information on life stories, go to [zestcommunications.com.au](http://zestcommunications.com.au) and [lifestoriesaustralia.com.au](http://lifestoriesaustralia.com.au).*



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# The shoulder epidemic – is surgery always the answer?

Shoulder pain is common and can be very debilitating, with rotator cuff dysfunction a frequent diagnosis. The treatment algorithms remain controversial – but is the significant upsurge in surgical rates for shoulder injuries justified? Recent evidence would suggest it may not be, reports **A/Prof Michael Sandow**.



**T**HE cause of shoulder dysfunction can be divided into a number of distinct conditions. Some conditions such as frozen shoulder may be difficult

to diagnose in the early stages, but most shoulders present in a relatively characteristic pattern:

1. Arthritis
2. Instability and ligament injuries
3. Frozen shoulder and calcific tendinitis
4. Rotator cuff dysfunction – tendinopathy and tears
5. Fractures

Rotator cuff tendinopathy and rotator cuff tears are a frequent cause of shoulder pain, and an understanding of some facts about these conditions can put the various treatment options into perspective.

## 10 facts about rotator cuff tears and tendinopathy

(Fact checker at [www.wakefieldshoulderclinic.com.au/facts](http://www.wakefieldshoulderclinic.com.au/facts))

1. It has been estimated that less than 10% of all rotator cuff tears that are present in people over the age of 60 are surgically repaired. That means that only a small proportion of rotator cuff tears are painful or limit activities. Being diagnosed with a tear does not mean surgery is the best option or is even needed.
2. However, some tears are painful and need to be treated. The goal of such treatment is to restore the shoulder to normal painless function and strength. This can often be achieved with the correct rehabilitation, with some patients ultimately requiring a surgical intervention.
3. Research suggests that for partial and full thickness tears, a specific exercise program can reduce the need for surgery by about 65%, and in fact, the published quality evidence is that the overall outcomes of surgery or physiotherapy are the same at one, two, four and five-year follow-up.

4. The treatment is generally in a staged manner to first exclude other conditions, then restore rotator cuff strength and flexibility, with those shoulders remaining symptomatic, possibly proceeding to surgery.

5. Some tears will enlarge and so, repair or at least ongoing treatment and monitoring may be required to avoid long-term problems. This, however, is a minority of shoulder tears.

6. Steroid injections can sometime help, but the benefits are generally just short term, and they may cause long-term damage, as there is good evidence that steroids can cause additional tendon tearing.

7. A plain x-ray is the most useful primary investigation for shoulder pain and will provide important information on many conditions including arthritis, instability and indicators of the chronicity of the possible cuff tear. Asymptomatic partial and full thickness rotator cuff thickness tears are very common, so finding a tear on an ultrasound is often not relevant – and a big waste of money!

8. There are very few shoulders that need urgent surgical care – the exceptions include persistent dislocation, complete rotator cuff tear following major trauma or if associated with fractures.

9. Symptomatic shoulders that respond to the right therapy will do so within three months. Strength usually returns by four weeks. Pain and function can settle quickly with the appropriate treatment, but high-end function – e.g. overhead activity/ repetitive manual work – can take longer.

10. Around 90% of those shoulders that do well with physio, will retain this improvement in the long term. It is important to maintain good cuff function, and so a vulnerable shoulder should undergo regular cuff strengthening exercises in the long term to avoid a recurrence of symptoms.

**Bottom line** – For best outcomes, current evidence supports careful assessment

and diagnosis, and an understanding of the natural history, as well as the range of treatment options. For most shoulder pain, early surgery is very infrequently needed if utilising the correct rehab program.

## When is URGENT surgery possibly required?

1. Displaced shoulder fracture
2. Dislocation (+/- fracture) with unstable joint
3. Complete massive sleeve avulsion of rotator cuff
4. Infection
5. Tumours (early review for decision on management)

## When is EARLY (at about a month) surgery possibly required?

1. Definite subscapularis tendon tears
2. Large multi-tendon tear with major strength loss
3. Failure to gain strength despite correct rehab program

## When is EARLY surgery not generally indicated?

1. Acute partial rotator cuff tears
2. Acute chronic rotator cuff tears
3. Long head of biceps tendon ruptures in the over 50 year old
4. When patients have not undergone correct rehabilitation.

Evidence-based physiotherapy works for most, and those that need further treatment such as surgery will do better for the preparation of pre-operative strengthening and mobilisation. However, incorrect exercises/ progression can lead to failed recovery and multiple flare ups. Details at [www.wakefieldshoulderclinic.com.au](http://www.wakefieldshoulderclinic.com.au)

*Michael Sandow FRACS is an orthopaedic surgeon at Wakefield Orthopaedic Clinic. He is also a past president of the Shoulder and Elbow Society of Australia, and current president of the Australian Hand Surgery Society.*





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# Leading anatomical pathologist farewelled

**Prof Douglas Henderson**  
AO, MB BS, FRCPA, FRCPath,  
FHKCPath (Hon)

1942-2018

**D**OUG Henderson was born on 19 July 1942, to Karoline Prestyniak-Mascha, from Austria, and Frederick Warrington Henderson from Scotland. The family moved a lot during the early years, eventually settling in Adelaide.

Doug went to Adelaide High School, taking part in cadet training and target shooting, but his proudest memory was the win of the yearly Adelaide rowing race, the 'Head of the River'.

He studied medicine at Adelaide University, on a Commonwealth scholarship, which was prestigious but associated with enormous performance pressure – a task he appears to have achieved easily.

After he qualified, he initially worked on the renal unit at the Queen Elizabeth Hospital but finally decided on a career in anatomical pathology.

He married fellow doctor Suzie Langlois in 1969, when he was a junior doctor. The couple had two children, Axel and Alida.

Doug's career in anatomical pathology extended over 48 years, 43 of them as a consultant. He was a recognised expert in pleuropulmonary pathology, and especially in asbestos-related disorders, and he published widely on asbestos-related diseases including several books and numerous peer-reviewed journal articles.

He was the South Australian representative for the pathology panel of the Australian Mesothelioma Surveillance Program and was a member of the extended panel of reviewers for the third revision of the International Histological Classification of Tumours of the Lung and Pleura, published under the auspices of the World Health Organization and the International

Association for the Study of Lung Cancer (WHO/IASLC).

In 2004 he was appointed as a member of the IASLC core panel of pathologists dealing with lung cancer diagnosis and classification and was a member of the International Mesothelioma Panel, which published a monograph on the Pathology of Mesothelioma, in 2006. In addition, he was an invited member of the international panel of four experts on asbestos-associated disorders, as an adviser to the World Trade Organization (WTO) Disputes Resolution Panel for the dispute between Canada and the European Communities on the importation of chrysotile asbestos (1999–2000).

**“Doug was a valued teacher and mentor to several generations of trainee pathologists, many of whom currently practice in senior positions throughout Australia.”**

He was an invited speaker and participant in many national and international conferences including as an invited participant and ceremonial co-chairman for the expert workshop on asbestos, asbestosis and cancer held in Helsinki in 1997 which formulated The Helsinki Criteria for Medical Report for the Court, on diagnosis and attribution of these diseases to asbestos exposure. He was also a participant and ceremonial co-chairman for the second Helsinki workshop held three years later, in February 2000, and participated in the formulation of the AWARD Criteria in Australia, for the attribution of lung and pleural disorders to asbestos (especially lung cancer).

Over many years, Doug received numerous referrals from within South Australia, interstate and overseas representing problems in the diagnosis and assessment of lung and pleural disorders, including mesothelioma and other asbestos-association disorders.



During his professional career he personally examined pathology samples from several thousand cases of malignant mesothelioma and several thousand cases of lung cancer, as well as numerous other cases of benign asbestos diseases of various types.

In 2006 he was awarded a Distinguished Fellow Award by The Royal College of Pathologists of Australasia, and in June 2010 was awarded the Distinguished Pathologist Medal of the Australasian Division of the International Academy of Pathology.

In June 2015 he was made an Officer in the Order of Australia (AO) for services to medicine, especially in the field of asbestos-related disorders. In October 2016, he was awarded emeritus professorial status by the Flinders University.

Doug also prepared numerous medico-legal reports (estimate: >4000) for courts and tribunals in Australia and the United Kingdom and was commissioned by solicitors acting for both plaintiffs and respondents, and by the NSW Dust Diseases Board, to prepare reports on both diagnosis and causation/attribution of pulmonary and pleural diseases.

Over the decades of his practice, Doug was a valued teacher and mentor to several generations of trainee pathologists, many of whom currently practice in senior positions throughout Australia. He will be sorely missed not only by his family and friends but also by the anatomical pathology community at large.

# Life as an intern

*medicSA* asked last year's AMA student medal winner Laura Sharley how life is treating her as an intern and for some advice for graduating students about to embark on the internship journey. Laura, who graduated from the University of Adelaide in 2017, has been interning in the SALHN network, primarily at Flinders Medical Centre in 2018.

## Is life as an intern as you imagined?

Life as an intern has been far more rewarding and enjoyable than I was picturing at 2am the night before my first day of General Medicine. I had so many irrational fears about being clueless, helpless and alone and was very pleasantly welcomed to Flinders Medical Centre with great support networks and friendly colleagues. I didn't realise how much I would truly enjoy working as a doctor, being part of the treating teams and the satisfaction good patient care can provide.

## What would be the greatest challenge you face as an intern?

It was a challenge to ensure a balanced lifestyle was maintained, even though I was very determined to do so. Overtime hours, late pre-admission clinics, cover shifts with complex unwell patients and many discharge summaries often lead to very busy days on top of the routine care required from your home team during hours. It did take me a couple of weeks to find the balance, but by having a few regular commitments it helped ensure the balance was met. Fellow University of Adelaide graduates and I started an AFL 9s mixed football team, and somehow between the Lyell McEwin and Noarlunga Health Service ED, we would get a team together every Wednesday for a run around and a kick of the football. This was a fantastic way to debrief about the week whilst being outside and getting some exercise.

## Why do you think it is important to be an AMA member?

Being part of the AMA enables you to be part of a national body that supports the medical profession, advocates for doctors and provides many other member services. Something that

you realise once you're out of medical school and working as part of the SA Health public health system, is the importance of advocacy required for doctors, for the patient's benefit and the health of a community as a whole. Having worked in the hospital with an overflowing emergency department, critical bed status and logistical challenges within the hospital, you gain a far greater respect for crucial organisations like the Australian Medical Association.

## Top tips for interns 2019

### 1. Ask for help.

- As an intern you will be doing a lot of tasks for the first time.
- If you don't understand what is being asked of you, seek clarification and advice to ensure you can do the task properly and safely. It will also save you a lot of time so you can be more efficient with your jobs!

### 2. Communication is key.

- With your team
- With your patients
- With your patient's family

### 3. Be a team member.

- You will enjoy your days at work much more if you are an integral part of the team.
- Get to know the nursing staff and allied health team early in your rotations.
- If there are any concerns within your team, don't hesitate to address these issues before they become detrimental to the workplace environment or patient safety.

### 4. Advocate for your patients.

- You see your patients more than others in your team, so you will be well placed to speak up for them.
- Acknowledge and address their concerns.



### 5. Document everything!

- You will often feel time pressured (... especially on early morning surgical ward rounds) but it is so important to have a clear assessment and plan documented so everyone can be on the same page.
- You will learn from your cover shifts how beneficial clear plans from home teams can be!

### 6. Take a second to stop and learn from the clinical exposure.

- Sometimes it can be easy to lose sight of the clinical cases when caught up with discharge plans, arranging tests and ensuring appropriate referrals are made. It is important to stop and learn from the cases to help better prepare yourself for the transition to residency (... the year goes very quickly!).

### 7. Ask questions.

- This will help you to learn the most you can whilst on the wards.
- Such discussions provide insight to the approach to clinical decisions from more senior medical staff.



### 8. Look after yourself and look after your colleagues.

- Self care is so important. Exercise and maintain good sleep hygiene (... and buy block-out blinds for night shift!), ensure you catch up with your friends and family, eat good food and enjoy a nice wine on a Friday night!
- Check in with your mates. It can relieve so much stress you may have been building within yourself, and you might start a conversation that your friend has wanted to have for a while!
- Remember there is 24/7 support for confidential phone advice if you or your peer needs it. Furthermore, there is great support available through Doctors' Health (see [doctorshealthsa.com.au](http://doctorshealthsa.com.au) for more information).

### 9. Make the most of your days off and annual leave to refresh.

- It's not always important to travel and do exciting things. Catching up on sleep and taking time to relax on your breaks is also vital!

### 10. Enjoy!

## Medical practices going green globally with WMA

**T**HE World Medical Association is urging physicians around the world to 'go green'. The WMA is offering physicians and their national medical associations a free online service, My Green Doctor, to add environmental measures and climate change awareness to their medical practices.

Dr Todd Sack, managing director of the service, said that most physicians and other health professionals who use My Green Doctor will save money by lowering office expenses.

My Green Doctor explains how the clinic starts its own Green Team that meets for a few minutes each week to make gradual changes.

Each step is described, so no environmental knowledge is needed. One American practice has been saving more than \$2000 per physician year.

The benefits of going green will be seen almost immediately, with savings to electricity and water bills.

The program goes on to help the practice to adopt wise choices in chemicals usage, recycling, food choices, and transportation decisions.

Tools for teaching patients and families good environmental choices and climate change preparedness are also a big part of what My Green Doctor offers.

*My Green Doctor is a free service for WMA members who register at [mygreendoctor.org](http://mygreendoctor.org). Members receive a free waiting room certificate – just for registering.*

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# Decision-making – a skill more than an instinct

Dr Troye Wallett explores decision-making and whether it is a skill that can be enhanced.



**E**VERY day, in every consult, we make decisions. Some of them are as simple as which ACE inhibitor to prescribe, and some are consequential,

such as whether to perform a cholecystectomy on an 84-year-old. Straightforward or severe, the decisions we make affect people's lives.

As doctors, we make these decisions quickly and mostly accurately. (If the latter was not true, our careers would be short-lived, and doctors' reputations would suffer.) The skill is a direct consequence of our training and knowledge of the clinical data. Medical school and specialist training are all about how to make good, accurate decisions.

Decision-making is not easy. Bookshops are full of volumes describing decision-making models and processes. It is interesting to note that the clinical decision-making framework fits into many models detailed in the lay literature.

For example, this one in the article titled 'How to make decisions, making the best possible choices' on MindTools.com<sup>1</sup>:

Step one is gathering information. We call it 'taking a history' and 'doing an examination'.

Step two is weighing up the options. Or, considering the differential diagnosis.

Step three is selecting the best alternative. Making the diagnosis.

Step four is communicating the decision and making a plan of action. Our 'shared decision-making'.

For us, as doctors, it is instinctual, but that does not detract from the skill required to execute the process. As with all models, this one frays on contact with the real world. It breaks down when decisions become more complex, the data is not black and white, or when there are two similar correct options.

For that, we add another step: consult with colleagues. This is another reason why clinical meetings, informal networks and remaining connected in the medical world are vital.



Another useful mental tool is the 'Would I regret it?' model – a practical way of conceiving risk. Medical training gives us the knowledge to weigh up risk, but using that knowledge in a specific and understandable manner can be useful. Let's explore the following case as an example of using this model.

Joan is an 84-year-old lady in an aged care facility who is on Warfarin for atrial fibrillation. Over the last few weeks, she has fallen four times. On the last occasion, she was found in a pool of blood from a scalp laceration. So as not to get caught up in clinical details, let's jump to the decision.

Should her Warfarin be ceased? Knowing the risks involved and the data, the GP uses the 'Would I regret it?' model: "If I ceased the Warfarin and Joan had a stroke next week, would I regret this decision?"

She then asks: "If I don't cease the Warfarin and she has a subdural haemorrhage, would I regret the decision?" Her final question to herself: "Which of these outcomes would I regret the least?" The benefit of this thought process is that she can share these questions with her colleagues, the team, the patient and their family.

The answer to those question expresses her knowledge about the risks of either decision and uses gestalt to make an accurate decision.

This decision-making tool asks one question multiple times and weighs up the answer:

"Knowing all that I know now, would I regret my decision if negative outcome X occurred."

The disclosure here is whether the 'Would I regret it?' decision heuristic is unverified in research and its efficacy remains a hypothesis. It works in an n=1 trial but requires a willing participant to decide to do the research.

## Exploring the 'Should I do this?' decision

If the willing participant were to consider doing the research, how might they go about making that decision? It is apparent that the project will take time, energy, financial resources and effort to pursue. Since this type of decision presents itself regularly, it seems prudent to explore what thought-leaders suggest about making wise choices and work through the decision on behalf of the willing participant.

Tony Robbins<sup>2</sup> suggests making decisions on paper. Extracting ideas from the turmoil of our minds gives them clarity. Hence, this article.

His next suggestion is, have a clear understanding of your purpose and direction. Another way of putting this is: For what are you optimising? What are your values? Thinking about one's

purpose, values and optimisation places the decision in the context of the big picture. It also helps to see the 'no' in the midst of inspiration. For example:

In the decision outlined above, allocating values creates tension. The value of 'making a difference' or 'being the best at what you do' conflicts with the value of 'spending more time with family' and 'optimising for freedom'. If the willing participant valued freedom above making a difference, the 'no' would become more evident. However, quantifying the values may reveal a different consideration. For example, perhaps doing the project will make a massive difference to the willing participant's field and impact freedom only slightly. In this case, it seems that considering values does make the answer clear.

Maybe thinking about risk-benefit will help our willing participant.

For help on this, we turn to Scott Adams, famous for creating Dilbert<sup>3</sup>. He puts weight into the process more than the outcome. He calls it 'process orientated thinking'. Are there benefits accrued in the process of the project or solely reliant on a positive outcome? If the journey gives as much or more than the destination, it minimises or eliminates the risk. Lower or no risk makes for an easier 'yes' decision.

Even if the research in question, is never published, the process is a learning and growth opportunity. Following that advice, our willing participant starts trending to a 'yes.'

However, there are other considerations.

"Hell yes! Or – no," says Derek Sivers.<sup>4</sup> If you are lukewarm about something then the answer is no. This rule protects one's time, which is a non-renewable resource. Having rules for choices helps with decision fatigue.<sup>5</sup>

Decisions take energy and effort, which makes them harder to make as more of them are made – a factor known as 'decision fatigue'. When decision fatigue kicks in, we fall back into habitual thinking. Habitual thinking is beneficial, as long as the habits are good. However, often it means that the easier option is chosen rather than the one requiring cognitive effort. Biases and prejudices are more apparent when people become fatigued. Making simple rules such as "I always say no to ..." helps prevent decision fatigue. Developing your own decision rules

leads to less decision fatigue and better decision-making processes.

For our willing participant, the cracks are starting to appear in the 'yes' decision. The idea of research is not quite at the 'hell yeah!' stage.

Finally, some advice from a less well-known mentor.

"What will I give up, to take this on?" Our lives are busy, and most of us have very little time for yet another project. Therefore, allocating the time required before taking on the project prevents late nights and unconsidered sacrifices. It seems obvious, but, in the midst of inspiration and excitement for a new project, this is often forgotten, and when the rubber hits the road, it is the time commitment rather than the decision that causes regret. A handy tip is to add the time to your calendar as part of the decision-making process. Beware of committing to time that detracts from social or 'down' time. It is easy to consider those times as useless, but they are vital to recharging.

For our willing participant, the time commitment is the factor that leads to the final decision. Research is not an option at the moment and is relegated to the 'future projects' list.

The final action is to document the reasoning and the final decision. Returning

to the decision and assessing it in six months or a year closes the feedback loop and is an opportunity to reinforce or adjust the above principles. This way, the willing participant's decision-making process becomes more robust over time.

Scott Adams would be proud. The outcome was almost irrelevant compared to the benefit this willing participant gained by exploring decision-making as a topic. The take-away is that making decisions is a skill that can be improved, and the effort required to develop that skill is never wasted.

*Dr Troye Wallett is a GP and the clinical director of GenWise (www.genwisehealth.com.au). He is a willing participant and made a decision to devote himself to public speaking and writing. He loves connecting and is contactable at t.wallett@genwisehealth.com.au.*

#### References:

- 1 [https://www.mindtools.com/pages/article/newTED\\_00.htm](https://www.mindtools.com/pages/article/newTED_00.htm).
- 2 <https://www.tonyrobbins.com/ask-tony/making-tough-decisions/>
- 3 <https://blog.dilbert.com/2013/11/18/goals-vs-systems/>
- 4 <https://sivers.org/hellyeah>
- 5 <http://psych.hanover.edu/classes/cognition/papers/tversky81.pdf>

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# Flow cytometry: what you need to know

**Dr Lakshmi Nath** and **Dr Shriram Nath** explain flow cytometry – a technology that has been used to analyse the physical and chemical characteristics of cells of interest in a fluid, which has been used in modern laboratories since the late 1970s.

**T**HE principle of flow cytometry is that cell components are fluorescently labelled with antibodies and then excited by laser to emit light at varying wavelengths. The fluorescence emitted is measured and interpreted based on light scattering properties and an expression of cluster differentiation antigens (CD). This allows resolution of white cells into lymphocytes, granulocytes, monocytes and blasts. The result can be visualised as a graphical representation.

Blood, bone marrow and lymph node have traditionally been classified by morphology using microscopy. Now, combination of antigens expressed on the cells has been used to characterize the cells by flow cytometry in cell samples or immunoperoxidase stain in tissue sections. This helps the medical scientist and the pathologist to have more information about the cells of interest. Flow cytometry has numerous applications in medicine and has become an important component in the diagnosis and monitoring of patients with a diverse array of diseases.

## The applications of flow cytometry

1. Monitoring of CD4 cell counts in patients on antiretroviral therapy and in other immune related disorders or chronic infections
2. Diagnosis and subclassification of B cell, T cell and Natural killer (NK) cell lymphomas, acute leukaemias, myeloma
3. Presence of significant lymphadenopathy, hepatosplenomegaly
4. Unexplained cytopenias like anaemia, neutropenia and thrombocytopenias
5. Non-malignant disorders like Paroxysmal Nocturnal Haemoglobinuria or red cell Membrane disorders like hereditary spherocytosis.

The samples that can be used are blood, bone marrow, lymph node, fine needle cytology (FNA), and any body fluids. All samples must be tested within 48-72 hours from time of collection. Tissue/fluid samples must be sent fresh or in saline or in Hank's solution and NOT in formalin.

## How does flow cytometry help in routine clinical haematology?

### 1. Assessment of persistent

*lymphocytosis:* Persistent lymphocytosis can be found in conditions like chronic infection, inflammation, auto-immune disorders, smoking, hyposplenism, or with drugs such as clozapine, lithium, carbimazole, and valproate but also in chronic lymphoproliferative disorders.

It is very difficult based on a blood film to definitely subtype lymphocytes and confirm whether they are reactive or neoplastic in etiology. Flow cytometry helps in this situation by differentiating between reactive and neoplastic lymphocytes based on light chain restriction (monoclonal) or polyclonal expression of kappa and lambda light chains. In samples which indicate a B cell lymphoproliferative neoplasm by flow, further subtyping into various B cell lymphomas or chronic lymphocytic leukaemia becomes possible, as does subclassification of T and NK cell lymphoproliferative neoplasms.

### 2. Diagnosis, sub classification and treatment monitoring of acute

*leukaemias:* Acute leukaemia can be classified into myeloblastic and lymphoblastic leukaemias based on expression of lineage specific CD antigens on blasts. Though bone marrow biopsy remains the standard for diagnosis, both flow cytometry and cytogenetics are recommended as it provides prognostic and therapeutic significance.

### 3. Myelodysplastic syndrome and chronic

*myeloproliferative neoplasms:* Flow cytometry aid bone marrow morphology by studying the maturation irregularity and aberrant antigen expression on various white cells.

### 4. FNA (cytology sample) and lymph node

*tissue:* It is difficult to establish subtype and clonality based on morphology alone in cytology and lymph node samples as the quality of specimen plays an important role. Flow cytometry

confirms whether a sample is reactive or neoplastic and also aids in subtyping.

### 5. Tissues with patchy or partial

*involvement by lymphomas:* When there are two populations (normal and abnormal) in a tissue sample, it is difficult to differentiate on the histopathology due to sampling artefact. Flow cytometry due to its increased sensitivity will be able to clearly differentiate between the two populations and clinch the diagnosis.

## Limitations of flow cytometry

1. Flow cytometry findings must always be correlated with morphology and clinical history.
2. In large cell lymphomas, false negative results can be obtained, causing discrepancy between flow cytometry and histopathology reports.
3. Hodgkin lymphoma remains outside the capability of flow cytometry for diagnosis currently.
4. For diagnosis of solid tumors like colon, breast and prostate cancer, flow cytometry is not useful. Histopathology remains the gold standard for diagnosis.

Following diagnosis, discussion with the hematologist regarding further management is advisable.

## When not to request flow cytometry?

1. Non-specific mild neutrophilia, monocytosis especially when morphology and clinical history is unremarkable
2. Chronic fatigue syndrome
3. Recent transient viral illness, bacterial infections, tiredness, sweats etc
4. For diagnosing solid tumour carcinomas.

*Dr Lakshmi Nath is a haematologist and clinical director of Haematology, Transfusion Medicine and Hospital Laboratories, Clinpath Laboratories; and Dr Shriram Nath is haematologist, Clinpath Laboratories and Adelaide Haematology, and clinical senior lecturer, University of Adelaide. References are available on request.*

# AMA(SA)'s history – now on the web

**M**EDICSA is pleased to announce in this December/January bumper edition the launch of the AMA(SA) historical website, prepared by its Historical Committee, which is now fully and publically available for viewing as described below. The site is entirely the work of the Committee and has thus been a very low cost exercise for the Association although a lot of work for those involved – especially Tom Turner – for which we must all be very grateful.

The Committee has a history of its own, having existed in two iterations, the first in the 1930s and the second in the current decade. Under the chairmanship of Trevor Pickering and just recently of David Fenwick, the Committee has done an enormous job of cataloguing and committing to electronic record much of the Association's history, particularly as reflected in biographies of all its past presidents from 1879 until the present day. This is well worth looking at on the website,

along with other features for which there are hotlinks. Included amongst these is Peter Kreminski's account of the Committee's activities over the past 87 years, an abridged version of which appears below.

## How to access the website

Simply go to: <https://wp.me/PagadV-4A> and explore! The following article tells you what's there to be seen, as well as a brief outline of the Committee's history and membership.

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## A short history and timeline of the AMA(SA) Historical Committee

The aim of the Historical Committee is to preserve the history of the AMA(SA) for the benefit of the medical community and in the public interest. In this article, **Dr Peter Kreminski** takes a look at the work of the current Historical Committee and from whence it came.

**T**HE current Historical Committee has been instrumental in digitising parts of the library, photographs, memorabilia, documents and portraits. The History Section of the AMA(SA) website has been visually improved (although more needs to be done). It links to a list of all 112 past presidents, serving in 115 terms of office.

Another link is to a Virtual Museum based on photographs of various artefacts which had been accumulated by our branch over many years. Further links are to the newly digitised AMA(SA) Centenary History as edited by Dr Bill Lawson (president 1978-1979) and published in 1979; the digital version of *Heroism, Humanity & Sacrifice* (published by the Committee in 2015 as a hard-cover book); a selected bibliography which includes the above Centenary book; and the South Australian Medical Heritage Society.

One more link is about to be installed. This is to a flexible WordPress site which 'is an evolving platform to bring to the notice of interested persons the past achievements of BMA/AMA members'. It now contains a

detailed exposition of all of our past presidents, with photographs of each and numerous hyperlinks. Other sections will include 'Other Eminent Practitioners' and an extension of the Virtual Museum.

## A timeline of the Historical Committee

The predecessor of the AMA(SA)'s Historical Committee can be said to have been the Historical Section of the SA Branch of the British Medical Association, although their objectives differ substantially.

### The Historical Section (1931–1936)

This body was formed on 3 August 1931 at the request of the Branch Council. As seen below it had several similar titles.

The inaugural chairman of the Section was the (double) Branch past president Dr Alfred A Lendon, but because of his illness past president Dr Frank S Hone acted in his place. The honorary treasurer and secretary was the future president Dr Leonard CE Lindon. The Committee comprised the above, plus past president Dr CT Champion

de Crespigny, future president Dr Edmund Britten Jones, immediate past president Dr Charles E C Wilson and Dr Albert R Southwood.

Consequently, the inaugural meeting of the section was held on 12 November 1931 at the residence of the above Alfred Lendon, 66 Brougham Place, North Adelaide (later the site of the Hotel Australia). Approximately 25 BMA members were present. Branch president Dr Alic V Benson opened the meeting and Lendon delivered an address to the 'Section of History of Medicine'. The title was 'Horae Medicorum Subsecivae' (a modification of the title of a book by the Scottish physician John Brown, 1810-1882). The subject was the recreational pursuits of medical practitioners, particularly those in South Australia, and the benefits arising from the study of the history of medicine.

The last record of the Section is that of 10 August 1936. The Branch secretary sent a letter to the honorary secretary of the Section, without naming him, and giving his address as simply 'Fullarton'. An undated envelope was sighted addressed to Dr HM Fisher



(Harry Metcalf 1899–1982), Secretary of the Historical Section. The envelope may have contained this letter.

**The AMA(SA) Historical Committee (2010-current)**

The modern body began in 2010 at the instigation of then president Dr Andrew Lavender, who asked Dr Dorothea (Thea) Limmer and past president Dr Jeanette (Jenny) Linn to re-organise documents and books held in the board room. Soon after, past president (state and federal) Dr Trevor Pickering joined them and was appointed the first chairman. Another early member was Dr Ross Philpot who resigned in January 2013.

**Membership of the Committee is best shown as a timeline:**

**2015 January**

Dr Thomas (Tom) Turner joins after an appeal from AMA(SA) President Patricia Montanaro

**2015 September**

Dr Peter Kreminski joins

**2016 June**

Jenny Linn retires

**2017 October**

Past President (Tasmania) Dr David Evans and Dr David (Dave) Fenwick join

**2017 December**

Trevor Pickering retires

**2018 April**

Thea Limmer retires

**2018 May**

David Fenwick becomes Chairman

Hence, in November 2018 the Committee was made up of Drs David Fenwick (Chairman), Tom Turner (Secretary), plus Peter Kreminski and David Evans (Committee members).

*The AMA(SA) Historical Society has six Terms of Reference to help it achieve its aim to preserve the history of the AMA(SA) for the benefit of the medical community and in the public interest. The Terms of Reference are set out in the full version of this article available on the website.*



*This bronze sculpture by Dr David Fenwick symbolises the past and future of the AMA.*



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# Keep your data systems safe and protect your practice

Keeping valuable data safe and healthy is as important for practice managers as caring for patients.



**C**LINICAL and financial records, practice information and documents are some of the most valuable assets to your business. And the focus

is increasingly on the digital collection, storage and sharing of important personal medical data – through the Government’s planned My Health Record, for example.

Hood Sweeney technology director Graham Wadsley says that having a backup system up and running before anything goes wrong can protect your practice from losing vital data, which is almost impossible to recover.

“With the increased reliance on clinical and practice management desktop systems and the electronic management of information, the implementation of appropriate data-management systems has become absolutely essential,” he said.

When a practice uses computers to store patient health information, the practice needs to have a sound backup system and a contingency plan to protect practice information in the event of an adverse incident, such as a flood, fire or theft.

“The loss of practice data can be catastrophic. If disaster strikes, you have the potential to lose patient records, financial accounts, inventory lists and payroll information,” he said.

A backup plan needs to encompass all critical areas of the practice’s operations such as making appointments, billing patients and collecting patient health information.

Once a plan has been formulated, it needs to be regularly tested to ensure backup protocols work properly.

To achieve accreditation, according to RACGP’s standards for general practice, practices must backup business-critical information.

It is recommended that practices have a reliable information backup system to support timely access to business and clinical information.

To meet accreditation, and for purposes of business continuity, ensure your practice backup process:

- is checked regularly (i.e. daily), including being able to recover the data



- is consistent with the business-continuity plan your practice has developed, tested and documented
- details how and in which offsite locations information is stored

The Medical Insurance Group (MIGA) also recommends a minimum retention period for health records from the last health care service provided:

- of at least seven years for adult patients or
- at least until a child turns 25 years of age if they were treated before they turned 18 years of age (this equates to seven years from the time that child turns 18 years old).

The use of electronic records does make the retention process simpler, however, a system should be in place to allow ready identification of records that are to be destroyed or kept.

Graham said having a proper backup plan protects your practice from potential disaster and allows you to get back online faster if any issues occur.

Hood Sweeney’s Technology team can work with you to find the best backup solutions for your practice.

“We have the ability to restore your data on our systems so you are able to access it via the internet to keep your business running until your infrastructure is working again. This service ensures business continuity in the event of a disaster – flood, fire or theft,” Graham said.

In addition to backups and disaster recovery services, Hood Sweeney Technology can help with your internet and cyber security, Office 365 and Cloud applications and, increasingly relevant for homes and businesses – preparations for the rollout of the National Broadband Network (NBN).

Already some of our Hood Sweeney clients have run into many service issues with their phone systems, internet and faxes – and that’s just the beginning. Your alarms, security cameras, elevator phone, EFTPOS and much more may also be affected as the NBN is rolled out across the state.

Let us address your questions now, so that when the NBN comes to your premises, you know exactly what you need to do.

Contact Hood Sweeney technology director Graham Wadsley for more information on 1300 764 200 or [techrecovery@hoodsweeney.com.au](mailto:techrecovery@hoodsweeney.com.au). Hood Sweeney is the AMA(SA)’s preferred provider for financial services.



# Minister announces two new listings on the Pharmaceutical Benefits Scheme

**T**WO major new listings on the Pharmaceutical Benefits Scheme (PBS) have the potential to extend the lives of Australians with advanced lung cancer and those at risk of a heart attack, saving patients almost \$190,000 a year.

From 1 November, patients with advanced lung cancer have the treatment Keytruda® subsidised for first-line treatment of metastatic non-small cell lung cancer (NSCLC).

Without PBS subsidy it would cost over \$11,300 per script or \$188,000 a year. Patients now pay a maximum of \$39.50 per script or just \$6.40 per “script for concessional patients, including pensioners.

This listing means that, for the first time, eligible patients with advanced lung cancer can avoid chemotherapy and be treated with this novel immunotherapy treatment Keytruda®. It will benefit about 850 patients a year.

Keytruda® is an immunotherapy medicine working with a patient’s own immune system to recognise cancer cells and destroy them. Clinical trials of Keytruda® for lung cancer has shown that some patients became virtually cancer free after treatment.



This medicine is already listed on the PBS for classical Hodgkin’s lymphoma and unresectable Stage III or Stage IV malignant melanoma.

The Federal Government is also listing Repatha® from 1 November for the treatment of familial hypercholesterolaemia, which is a genetic high cholesterol condition. More than 6,000 people with the condition, who are at risk of having a heart attack or stroke at an early age, will benefit from the treatment.

Patients would normally pay around \$630 a script, or more than \$8000 a year. With its listing on the PBS, eligible patients now pay a maximum of \$39.50 per script for Repatha or just \$6.40 with a concession card.

The independent Pharmaceutical Benefits Advisory Committee (PBAC) recommended the listings that have been announced.

The Committee is independent of government by law and in practice. By law, the Federal Government cannot list a new medicine without a positive recommendation from PBAC.



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# Free teenage vaccines for meningococcus

Recent teenage deaths from meningococcus have been the catalyst for new funding towards a greater immunisation program.

**T**HE Federal Government has launched a new free national program for 14 to 19 year olds, and committed \$52 million to the program. More than one million teenagers will receive the free meningococcal A, C, W and Y vaccine over the next four years.

It will be added to the National Immunisation Program from April 2019 and given to students aged 14 to 16 years under a school-based program. Adolescents aged 15 to 19 years of age, who have not already received the vaccine in school, will be able to receive the vaccine through an ongoing GP based catch-up program.

In recent years, there has been a rise in the number of invasive meningococcal disease cases in Australia. In 2017, there were 382 cases reported nationally, compared with 252 cases in 2016 and 182 cases in 2015.



The Minister's announcement follows a recommendation from the Pharmaceutical Benefits Advisory Committee (PBAC) to list the meningococcal A, C, W and

Y vaccine for adolescents. This is in addition to the state-funded program for meningococcal B vaccines for young people in SA.



*The sapmea Board and staff would like to sincerely thank the Adelaide PHN, Country SA PHN, RTWSA, our sponsors, presenters and attendees for making 2018 such a great success!*



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# Disability Support Pension Medical Evidence Checklist for treating health professionals

In responding to members' concerns, the AMA has worked with the Department of Human Services to provide clarity around medical evidence required for a Disability Support Pension applicant. As a result, the new *Disability Support Pension Medical Evidence Checklist for treating health professionals (SA478)* form is now available.

Members informed the AMA that better support for GPs and other medical practitioners who provide medical evidence for a Disability Support Pension applicant was required. In response, the AMA has worked with DHS to provide clarity around eligibility requirements, what type of medical evidence is required, what payments are available to practitioners for assisting with the gathering of medical evidence and, if called, for discussing medical evidence with an assessor.

The use of the checklist is optional, but may help in ensuring the provision of relevant information, and may help DHS to better understand a patient's circumstances and allow them to:

- assess their claim or medical review more quickly
- reduce the need to ask the patient for additional medical evidence
- avoid the need for further contact with the treating doctor or the patient's other treating health professionals, to clarify the medical evidence.

As well as the checklist, the PDF fillable form includes information to help medical practitioners support their patients who are claiming Disability Support Pension (DSP).

The form design takes into account previous feedback from the AMA on behalf of members. DHS has advised



they welcome further feedback and will continue to review the form to ensure it meets the needs of treating health professionals and patients claiming DSP.

*The form is available here:*  
[humanservices.gov.au/individuals/forms/sa478](https://humanservices.gov.au/individuals/forms/sa478).

## INTRODUCING

# DR LUKE MOONEY

HIP, KNEE, SHOULDER SPECIALIST

Dr Luke Mooney has recently joined Wakefield Orthopaedic Clinic.

Luke's focus is assisting patients suffering pain and dysfunction related to hip and knee arthritis, and knee or shoulder instability or soft tissue injury. Trained locally and internationally in arthroscopic and minimally invasive techniques, Luke is committed to minimising patient pain, increasing function and quality of life while remaining respectful and responsive to the needs of patients. **Keeping patients moving is his priority.**

Dr Mooney consults and operates at these locations:

[Wakefield Orthopaedic Clinic](#) | [Royal Adelaide Hospital](#)  
[Queen Elizabeth Hospital](#) | [Mount Gambier and District Health Services](#)  
[Riverland Regional Hospital](#) | [Naracoorte Health Service](#)

**Dr Luke Mooney | Orthopaedic Surgeon**  
**MBBS, FRACS, FAOrthA**

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**Fax** [08] 8236 4110  
**Web** [www.woc.com.au](http://www.woc.com.au)

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# New end-of-life planning resources available

A new free resource is now available encouraging GPs to have conversations with their older or chronically ill patients about planning for the future when they may become very unwell or require end-of-life care.

The Advance Project was developed by HammondCare, who specialise in aged care, dementia care and palliative care.

Director of Centre for Learning and Research in Palliative Care, Prof Josephine Clayton, said: "GPs are in an ideal position to start advance care planning discussions with their patients because of their trusted relationship. They have an essential role in providing palliative care to patients and their families, and starting this conversation early."

The Advance Project website and toolkit of resources provides free training about initiating conversations

on advance care planning and assessing patients' and carers' palliative and supportive care needs. It also includes free booklets for patients and carers.

The resources in the Advance Project include:

- online learning resources such as eLearning and support for implementing the resources into general practice
- individual tele-mentoring for participating clinicians from across Australia
- grants and train-the-trainer support for champion networks to deliver face-to-face training and to support implementation of the model into clinical practice.

The project is funded by the Australian Government Department of Health, with training endorsed by the

Australian Primary Health Care Nurses Association (APNA) and accredited by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) and delivered by a national consortium led by HammondCare.

For more information, go to: [theadvanceproject.com.au](http://theadvanceproject.com.au).

## New Disasters and Mental Health Support page

SA Health has launched a new page as a central location for information and resources about mental health support in times of disaster and trauma. The page is for service providers and the community and aims to minimise the impact of trauma, grief and loss, and to help people feel safe, connected to others, calm and hopeful. Go to: [sahealth.sa.gov.au/DisastersAndMentalHealthSupport](http://sahealth.sa.gov.au/DisastersAndMentalHealthSupport).

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## NOTICES

**ADELAIDE CANCER CENTRE** would like to advise of our new consulting suites at Windsor Gardens. See our ad on page 36.

**ADELAIDE PHOBIA CLINIC** – Introducing Adelaide's first clinic focussed on the treatment of specific phobias. Using evidence-based virtual reality exposure therapy patients can overcome their fears, including phobias that may be impeding their medical treatment. We have treatment programs for needle phobia, claustrophobia (with MRI virtual reality environments) along with animal phobias (spiders, snakes and dogs), fear of heights and flying. Phone 8379 6289, fax 8121 7652, [www.adelaidephobiaclinic.com.au](http://www.adelaidephobiaclinic.com.au).

**FOOT & ANKLE CENTRE** and team wish to welcome Dr Gayle Silveira to the practice. The Foot & Ankle Centre is based at Specialist Central, 22 Walter Street, North Adelaide. Established in 2005, the Foot & Ankle Centre is an 'Australian first', South Australian owned multi-disciplinary centre that specialises in the comprehensive treatment of foot and ankle disorders. The practice is recognised as a centre of excellence in Australia.

Early intervention is key to successful outcomes. We see patients in a timely fashion and have extensive experience in preventative care, surgical and non-surgical solutions and rehabilitation. Our providers are experts in the medical, surgical and bio-mechanical treatment of the foot and ankle.

The team of orthopaedic surgeons, surgical assistants, musculo-skeletal, GP and allied health services offers a comprehensive range of multi-disciplinary treatment and support services.

We have a unique approach to foot and ankle care providing professional services tailored to the individual needs of the patient in one convenient location. All this expertise works together to achieve the best possible outcome for patients. Our growth in the community is the direct result of the expert, professional, caring and personal treatment given to our patients.

For all appointments please call 8334 5900 or email [info@specialistcentral.com.au](mailto:info@specialistcentral.com.au).

**DR GAYLE SILVEIRA, orthopaedic surgeon** wishes to announce she will be joining Dr Linda Ferris and team in private practice at the Foot & Ankle Centre, 22 Walter Street, North Adelaide.

Dr Silveira is Fellowship trained in foot and ankle (orthopaedics) and lower limb trauma. She will begin her private practice consulting in February 2019.

Dr Silveira is happy to see private, WorkCover and motor vehicle accident patients.

For all appointments please call 8334 5900 or email [info@specialistcentral.com.au](mailto:info@specialistcentral.com.au).

**RICHARD HAMILTON MBBS, FRACS, plastic surgeon**, wishes to announce that his private clinic Hamilton House Plastic Surgery remains fully re-accredited under the new National Standards (NSQHS) and also by the American Association for the Accreditation of Ambulatory Surgical Facilities International (AAAASF).

Richard Hamilton continues to practise plastic surgery at Hamilton House, 470 Goodwood Road Cumberland Park with special interests in skin cancer and hand surgery.

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

For convenience, referrals may be faxed to 8373 3853 or emailed to [admin@hamiltonhouse.com.au](mailto:admin@hamiltonhouse.com.au). For all appointments phone his friendly staff at Hamilton House 8272 6666. See [www.hamiltonhouse.com.au](http://www.hamiltonhouse.com.au).

**480 SPECIALIST CENTRE** – MRS Property is pleased to announce the opening of this state-of-the-art centre at 480 North East Road, Windsor Gardens. A small number of specialist consulting room tenancies are still available together with sessional suites. The following specialists are currently consulting from the new centre:

**Adelaide Cancer Centre** – Dr Carolyn Bampton, Dr Sarwan Bishnoi, Associate Professor Dusan Kotasek, Dr Dainik Patel, Dr Nimit Singhal, Dr Amy Hsieh, Dr Anna Mislang, Dr Stanley Cheung

**Eye Surgeons SA** – Dr Paul Athanasiov, Dr Weng Onn Chan, Dr Neena Peter, Dr Remin Nath

**Colorectal Surgery** – Professor Peter Hewett, Mr Andrew Luck, Mr Darren Tonkin, Dr Elizabeth Murphy, Mr Shanthan Ganesh, Mr Jimmy Eteuati, Mr Christopher McDonald, Mr Jonathan Yong

**SA Group of Specialists** – Dr Marc Le Mire, Dr Hamish Philpott, Dr Mahinda de Silva, Dr Paul Spizzo, Dr Lachlan Dandie, Ms Jenny Carney, Prof Ian Spark

**Medical Lasers & Dermatology** – Dr Tim Edwards, Dr Kyoko Shirato

Contact information for appointments, referrals and general enquiries can be found at [www.480specialistcentre.com.au](http://www.480specialistcentre.com.au). See ad on page 37 for more details.

**CHRIS WORTHLEY MBBS, FRACS, HPB and general surgeon**, wishes to advise that he will be ceasing all clinical practice on 31 December 2018; since 15 September 2018, he has not been seeing new referrals. Patients previously managed by Chris may phone the current rooms on 8210 9488 (after hours 8344 9521) for re-appointments or advice on follow-up. Chris would like to thank all those who have supported him in his clinical work over many years.

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Room or sessions for lease in a psychiatry/psychology practice. Quiet location at Egmont Tce, Hawthorn, with excellent patient parking. Great peer support available. Contact Dr Michelle Atchison on 0411 728 033.

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### NORWOOD

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Contact Dr Joe Levy on 8554 3250 or email [joe.levy@bigpond.net.au](mailto:joe.levy@bigpond.net.au).

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practice, with 10 consulting rooms, a three-bed treatment room and an area for minor procedures. We have onsite pathology and para medical rooms. Requirements include: postgraduate training and experience in general practice; eligibility for registration with the national medical board (VR registration highly regarded); caring, friendly disposition; minor treatment room procedure skills; medical Indemnity Insurance and police check. Contact Sally Collins on 8562 2444 or email [scollins@nuridocs.com.au](mailto:scollins@nuridocs.com.au).

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