medicSA
FEBRUARY 2021 VOLUME 34 NUMBER 1


# Special delivery

## Managing the vaccine roll-out

AMA
SOUTH AUSTRALIA

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# Contents




South Australia's 2021 Rhodes Scholar and AMA(SA) member Dr Sarah Short has travelled a long way in her professional and personal life – and has recently added competing in triathlons to an already awe-inspiring list of achievements.

# Is your practice protected?

Running a medical practice is as much about managing risk as providing healthcare. When poor patient outcomes result from lapses in processes or staff error, it's not only practitioners and your team at risk – the practice itself can be exposed to legal action.

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# President's report

**Dr Chris Moy**

COVID-19 is certainly the gift that keeps giving. Who in February 2020 could have foretold that 12 months later the world would still be grappling with the devastating impacts of COVID-19? That those of us in Australia would have extremely limited opportunities to leave – and be happy about it? That South Australia would be one of the few places in the world where the vast majority of people listen to science?

There has been and continues to be so much to do. But I am extremely proud of how doctors and the AMA have 'stood up' over the past year. Our work has been incredibly important in so many spheres, and despite how many times you've heard my voice on radio, only a fraction of our advocacy has hit the media.

In recent weeks, the major topic in our meetings with Australian Government officials has been the involvement of GPs in the vaccine roll-out. Again, I'm pleased that we have been able to open the eyes of the government to the key role that GPs should play. GPs know their patients and their medical backgrounds; the word of trusted GPs is likely to increase a patient's confidence in the vaccine's safety. With the appropriate support, GPs can adapt their practices to ensure vaccines are delivered across the country, in a COVID-safe manner, while continuing to provide usual care to their patients. It should have been a no-brainer, but it wasn't.

And as a result of our work, GPs have been allocated an estimated $1-1.5 billion of funding support to administer the COVID vaccine in the community.

It has been somewhat concerning, therefore, to hear that some have complained that we did not work hard enough; that we have somehow 'sold them out'. To these, and others, can I urge you to consider – for a community which has felt widespread pain from the direct and indirect effects of the pandemic – that the COVID-19 vaccine roll-out is a time to look past our own needs and is our moment to stand up. The profession has earned the thanks of the community for our roles in combatting the virus to date – something that may be diminished if the community senses complaint and self-interest among doctors, even if only from a few of us. The AMA will continue to work for doctors and patients to help Australia through this, and I hope all doctors will understand their key role in the big picture of the vaccine roll-out.

As March approaches, and we look forward to what we hope will be a time of less anxiety and greater certainty, please spare a kind thought for our medical students. The time spent as a university student is arduous enough in the calmest of times; throw in a pandemic and it's been a nightmare.

One of the impacts has been on the normal rites of passage from medical school to internship. As you'll see on page 26, AMA(SA) has had to postpone the announcement of our 2020 Adelaide Medical School Student Medal winner due to pandemic restrictions on public gatherings. But we were very glad that the Flinders Medical School managed to stage its commemorative event, and congratulate joint AMA(SA) Student Medal winners Matilda Smale, who was a valuable contributor to AMA(SA) Council as the Flinders representative in 2020, and Liam Ramsey, who wrote for medicSA as the Flinders Medical Students' Society President last year. I am certain that Dr Smale and Dr Ramsey will be strong advocates for their colleagues as interns and in their future careers.

At 'the other end' of their careers (usually!) are those AMA members who received recognition in the Australia Day Honours last month. In 2020, we were proud to have our own member, Dr James Muecke, named as Australian of the Year, and watched as he used this invaluable platform to inform and educate Australians about the dangers of sugar. I'm very much looking forward to seeing the AMA building on and promoting the work James and others are doing.

As I write this, the House of Assembly is debating the Termination of Pregnancy Bill 2020, which was delayed from early February to late this month. The AMA has been publicly supporting the Bill in its ambition to decriminalise abortion in this state – the only one in Australia where abortion remains in the criminal code. I am sure there will be more to say in the next issue of *medicSA*.

In the meantime, we begin the vaccine roll-out. It will be challenging – but I am very confident that together we can perform our expected role in supporting Australia in and through this critical period.

# Editor's letter

Dr Philip Harding

It is a wonderful thing, to be a doctor. We have so many opportunities to perform important work that helps the lives of our patients, their carers and loved ones, and the communities in which we live. If there was a chance that we forgot the value of our profession, the pandemic has provided constant reminders of it.

But there are those of us who do go above and beyond in serving our patients and communities – who do more at home or venture overseas to care for and protect the health of people in need. Sometimes, the work and its importance are never known or sufficiently recognised, even among the medical fraternity. At other times, acknowledgement comes later. In this issue, we recognise four South Australian medicos who received Australia Day Honours last month: Dr Roy Scragg AM OBE, Dr John Crompton AM, Dr John Willoughby OAM and Dr David Hamilton OAM. We hope this additional exposure in some way reinforces the appreciation we feel for all they have done.

*Pam Spry AM, and nursing in 1948*

But health care is not and has never been just about doctors. Our patients wouldn't achieve the levels of health we want them to without the thousands of nurses, allied health professionals and other health care workers who work alongside us to improve patients' health and lives. COVID-19 has provided daily reminders of that, too. Last month, my wife Margie and I attended the funeral of former Royal Adelaide Hospital Director of Nursing Pam Spry AM. Pam held many positions in nursing and health in this state, Sydney and Melbourne, including as one of the first staff members at the Queen Elizabeth Hospital in 1959, and also worked overseas. She was a Commissioner at the South Australian Health Commission, and a member of the planning team for the first college-based nurse training course at the then-Sturt College of Advanced Education. She advocated for fairer conditions and promotion opportunities for her fellow nurses and for diversifying the range of nurses, including more males.

At her funeral, I recalled Pam's dedication, her curiosity, her close working relationships with senior medical colleagues such as now-Professor Brendon Kearney and me, and her sense of humour. I remembered that during the building program at the old RAH in the 1990s, when the link on the upper level between Teaching and Services and the Eleanor Harrald Building was to be named 'Spry Way', much merriment ensued when CEO Nobby Elvin dubbed it 'Pam's Passage'.

'Matron Spry' was 96 when she died. I like to think she was happy with her 'innings', despite not quite reaching the ton, and that she was aware that her contribution was, and will continue to be, remembered and appreciated.

# New access to mortgage advice

With hundreds of loans to choose from and multiple banks and institutions to deal with, busy doctors may not have time to identify which loan best suits their needs.

AMA(SA) CEO Dr Samantha Mead said she welcomed the opportunity to work with WA-based AMA Mortgage Brokers to offer local AMA members targeted mortgage broking services.

AMA Mortgage Brokers is a service now available to AMA members and non-members across Australia. Mortgage broker Racheal Warne said the company can help navigate the competitive and ever-changing mortgage landscape to help find the right loan for each individual.

Ms Warne said some loans may not offer the flexibility doctors need for the future.

'Mortgage brokers have a legal duty to make credit recommendations that are in the best interests of the client. Brokers also have the experience to help choose the right loan for each person,' she said.

'Some products seem to offer a great deal but may have penalties, fees and charges that others may not be aware of. We will be across this and will help AMA members avoid taking out loans they later regret.'

A new cashback offer available to AMA South Australia members allows eligible people to receive up to $2,000 cashback on any loans successfully settled between 4 November 2020 and 31 December 2021. The cashback offer is in addition to any bank or lender cashback offers (if eligible), leaving customers with more cash in their pockets.

For more information see https://www.amafinance.com.au/home-loans/cashback-offer/


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MEDICAL IMAGING

NEW SERVICE

## Bone Density Port Augusta & Gawler

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

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

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

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

UPGRADED MAGNET

## MRI at our Modbury Clinic

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

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All other imaging not Medicare indicated can still be performed on this scanner.

COMING MID-MARCH

## MRI at our Gawler Clinic

We are installing MRI at our Gawler clinic, located within the Gawler Health Service.

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

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

We anticipate services commencing mid-March.

*Where clinically indicated


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# The rights approach

Human rights academic Professor Wendy Lacey and aged care activist Daniella Greenwood write that a human rights approach to caring for older Australians will transform conditions that have led to a Royal Commission and been in the spotlight again during the pandemic.

Human rights do not change simply because we age. No human right disappears when we reach 65 years of age or when we start receiving aged care services. As professionals in the sector, we must ensure that we preserve the human rights of older Australians, at every turn. The failure to do so means we will be letting down our most vulnerable patients, neighbours, family members and friends.

Around $27 billion a year goes into the provision of aged care in Australia – 76 per cent of this is covered by government subsidies and 21 per cent by individual private contributions. Residential aged care providers receive around 18 billion of the total annual aged care spend -$13 billion in government subsidies and a further $4.8 billion from resident contributions. None of these figures include the estimated $41.7 billion that is spent on the health care needs of Australians aged 65 years or over.

These are the types of figures that take centre stage in articles and conversations about the state of aged care in Australia. The figures provide answers to important questions such as how much? Who gets it? What is it achieving? Can it be done more efficiently in light of an ageing population? But the figures do not provide an answer to the most pressing question we are called upon to ask ourselves as a community – how do we want to grow old together in Australia?

When it comes to residential aged care, it seems we are spending $18 billion annually on something that no older person wants – at least no one wants what it currently *does*, with some saying they would rather die than move into a residential aged care facility. It is estimated that 39 per cent of residents living in residential aged care have experienced some form of emotional abuse, neglect or physical abuse, and these statistics are no doubt conservative and do not include instances of financial or sexual abuse.

As the Royal Commission into Aged Care Quality and Safety has already disclosed, additional investment has not resulted in better outcomes for older people.

None of this is news to those who have been following the Royal Commission, least of all members of the medical profession who have long been calling for a complete overhaul of the aged care system. A key outcome of the Royal Commission is very likely to be the creation of a new *Aged Care Act* based on human rights principles. This shift constitutes more than an overhaul – it requires a complete re-engineering of aged care services in Australia. It will also require a paradigm shift among medical professionals.

## A HUMAN RIGHTS APPROACH TO AGED CARE

It is important to stipulate that excellent medical care where needed is fundamental to a human rights approach. This includes ensuring GPs are at the centre of medical planning and that there are enough aged care staff and registered nurses to provide skilled and humane care and support.

A system underpinned by human rights demands clarity around what does and does not come under the umbrella of medicine. This is particularly vital in residential aged care where everyday decisions, tasks, desires, expressions and functions – all central to human rights and citizenship – are frequently subject to medical sanction, the opinions of family and aged care staff, or to the strict routines in care homes designed to optimise financial efficiencies. Currently, all aspects of an older person's life are on the table for others to approve of, make decisions about or override – frequently for the older person's 'own good'.

*Human rights academic Professor Wendy Lacey*

## PATERNALISM AND DECISION-MAKING

A commitment to human rights law and norms moves aged care beyond patient-centred approaches that have failed to protect the rights of the most vulnerable – particularly the right to self-determination. Based on the closing submissions of Senior Counsel assisting the Commission, a rights-based approach will be embedded in new law and policy. However, we do not yet know what that will look like in terms of the detail for health professionals.

What we do know is that it will require considerable effort in calling out paternalistic practices that have been codified and normalised across aged care. The normalisation of these practices has occurred because paternalistic attitudes and assumptions in relation to vulnerable older people are largely invisible and accepted. Paternalism is the anthesis of human rights.

There is considerable overlap with discussion of the rights of persons with disabilities –particularly in the area of decision-making. Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD) seeks to address the legacy of paternalism and the stripping away of human and citizenship rights associated with substitute decision-making. It outlines the rights of persons with disabilities to enjoy 'legal capacity on an equal basis with others in all aspects of life', highlighting that people have a right to make their own decisions and to be

*Aged care consultant Daniella Greenwood*

provided with decision-making support that gives effect to their current will and preferences. The CRPD and Article 12 cover a broad range of disabilities including the physical and sensory disabilities experienced by older people and the cognitive changes experienced by people living with dementia.

We argue that in situations where the currently expressed will and preferences of an older person are contested, a threshold in relation to the severity and likelihood of the proposed harm to the individual or others must be established. This is vital in ensuring that the approach adopted in cases of serious and imminent risk is not applied to everyday decisions that others in the community would expect to be permitted to make for themselves, without medical or family sanction.

## HUMAN RIGHTS FOR THE MOST VULNERABLE

It is estimated that 70 per cent of residents living in aged care institutions are experiencing some form of cognitive decline, yet the system still persists with survey, assessment and evaluation methods that do not accommodate people experiencing a range of cognitive changes. It is the equivalent of not providing wheelchair ramps, Braille resources or sign language interpreters to support the inclusion of all abilities. Under a human rights approach, efforts to promote decision-making, choice, and engagement with care planning and quality assurance processes will have to be re-designed to accommodate these people so that their voices can be heard beyond proxy accounts and inputs.

This will involve re-engineering an aged care system founded on consumerist and market-based principles and ideology. Human rights cannot be left in the hands of market-forces, because vulnerable people are not consumers with the capacity to engage in complaint mechanisms or abandon services that are below par. A human rights approach recognises that vulnerability is part of the human condition and, thus, it is the responsibility of society to include and support vulnerable citizens – that this is a moral responsibility that cannot be outsourced or left to the whims of the profit motive.

## CONTINUITY

Understanding the currently expressed will and preferences of vulnerable people and those living with cognitive changes such as dementia requires time and patience in the context of long-term relationships. Adhering to Article 12 of the CRPD means a commitment to continuity of care and consistency in care and therapeutic relationships as a reasonable accommodation to support human rights. In this respect, changes to the aged care system must prioritise the maintenance of long-term therapeutic relationships between older citizens and their GPs, and consistency in the staff providing day-to-day care in a community or residential aged care context.

## MOVING BEYOND HIGH-LEVEL ABSTRACT PRINCIPLES.

In their submission to the Royal Commission, the AMA pointed out the danger in relying on high level and 'potentially vague' principles such as those underpinning the new Aged Care Quality Standards, including the risk that these will translate to little more than a 'tick box' administrative exercise on behalf of aged care providers. The same danger exists with the shift to a human rights approach, which is why there must be clarity in a range of observable and measurable human rights expectations and non-negotiables relating to the practice and operations of aged care services.

## HOW CAN MEDICAL PROFESSIONALS SUPPORT HUMAN RIGHTS IN AGED CARE?

- Model behaviours and practices that reflect respect for human rights – the right to health is not the only human right.
- Ensure that legal powers are used only for the explicit purposes they are meant to under law, as required, and always giving effect to the current will and preferences of the individual.
- In situations where the capacity to express decisions and preferences is most compromised, the current will and preferences of an older person is a measure of their self-determination and it is a matter of human rights that this be upheld (not someone's opinion of what is 'best for them' or based on a memory of the way someone 'used to be').
- Model threshold thinking in situations where the currently expressed will and preferences of an older person is at risk of being overridden - demanding that the threat of serious and imminent risk to the person or others be established *before* paternalism is considered.
- Clearly articulate the areas that come under the umbrella of medicine and those that do not. Medical professionals – particularly GPs – can assist the aged care workforce in understanding the importance of teasing apart the medical from all other aspects of people's lives.
- Acknowledge that in supporting the most vulnerable citizens in the community there is a risk of creating 'perfect and compliant' patients – often because their expressions of preference take time and patience to understand, and/or because these expressions are simply overruled, ignored or pathologised by aged care professionals.
- Ask different questions when presented with the possibility of prescribing psychotropic medication in a residential aged care context. A human rights approach calls for a range of practice and operational non-negotiables such as relaxed schedules, consistent staffing, and affording adult-status in communications and interactions. These shifts can influence the behaviour, moods, protests and responses of people living with dementia and so it is vital they are in place *before* medication is considered.

*Daniella Greenwood is an international consultant in human rights policy and practice in residential aged care. Professor Wendy Lacey is Executive Dean of the Faculty of Business, Government & Law at the University of Canberra. Her research has centred on the rights of older persons and the prevention of elder abuse.*

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# Local prescribers embrace e-scripts

The ease of use and benefits to doctors and patients are prompting the rapid adoption of 'ePrescriptions' in South Australia.

*Andrew Matthews*

*Sarah Wiles*

The number of electronic prescriptions in South Australia increased dramatically as electronic prescribing formally expanded in December 2020. More than 500 prescribers are now using them across the state.

Adelaide's COVID cluster in November provided a catalyst, enabling general practice management software and pharmacy dispensing software to be upgraded with a new electronic prescription functionality that boosted the number of general practices using the technology.

Australia's COVID-19 National Health Plan and the fast-track implementation of electronic prescribing to support telehealth measures were announced in March last year. Country SA PHN's Manager of Digital Health and Systems Integration, Sarah Wiles, says electronic prescribing provides advantages beyond the immediate benefit of a single electronic script, especially as telehealth has been announced as a permanent Medicare subsidised fixture in Australia's health system.

'The viability of telehealth consulting has always been constrained by the limitations of a paper prescription as the only legal form to supply medicines,' Ms Miles says. 'Even beyond COVID-19, it will be a great advantage for a rural patient to have a telehealth consult with a doctor in Adelaide and receive their prescription electronically.'

The Australian Digital Health Agency (ADHA) has been responsible for the technical framework for electronic prescribing and the national implementation, with the Department of Health. ADHA's Director of Medicines Safety, Andrew Matthews, says more than 98 per cent of South Australian community pharmacies are now dispensing electronic prescriptions.

'Since the first ePrescription was generated in May 2020, more than three million have been issued nationally,' Mr Matthews says. 'Prescribers can be confident that if a patient prefers an electronic prescription from their doctor over a paper prescription, they will be able to get this dispensed at their local community pharmacy.'

General practices and community pharmacies should communicate to ensure they are ready to write and dispense electronic prescriptions, he says.

Mr Matthews says medicine safety, including errors in transcribing medication into drug charts, was a focus of the Royal Commission into Aged Care Quality and Safety. Electronic prescriptions will support GPs in managing medicines safely, including in residential aged care facilities, he says.

Adelaide GP and AMA(SA) Councillor Dr Danny Byrne is an early adopter of ePrescribing. 'Electronic prescriptions have proven their worth for simple, one-off scripts in conjunction with telehealth, and dramatically simplified my workload for bulk repeat scripts for aged care home residents,' he says.

'With a telehealth consult, a patient doesn't have to come to the surgery to pick up the script and we don't have to fax it to the chemist. It's now a three-second process.'

With patients receiving their ePrescription 'tokens' by mobile phone or email, Dr Byrne says it is critical patients' contact details are accurate, to avoid a potential breach of privacy. 'The important thing is to think before you click to issue an ePrescription, to ensure the mobile number is the correct one,' he says.

Pharmacists are also beginning to use the Active Script List (ASL), another ePrescription option. The ASL includes a patient's active prescriptions and repeats that may be dispensed. Patients who choose to use an ASL will not need to keep their prescription tokens. ASL will be increasingly available from April, and functionality is expected to improve during 2021.

Ms Wiles says ASLs will be especially useful for doctors caring for patients in residential aged care facilities. 'Access to and use of the ASL will provide another option for patients to track and manage their prescriptions with no more repeat requests due to lost scripts,' she says.

She predicts that ASLs will become more useful in aged care facilities as online medication charts are integrated with software systems. 'It will enable a prescriber to send the prescription directly into the medication chart and notify the pharmacist for dispensing, with alerts on the chart for administration in the facility,' Ms Wiles says. 'That is a single entry - no more transcribing of medications.

'Being ready for ePrescribing will also set GPs up to participate in South Australia's Real Time Prescription Monitoring (RTPM) Script Check, which is due to start roll-out in March.'

For more information about electronic prescribing and electronic prescriptions:

- Department of Health: www.health.gov.au/initiatives-and-programs/electronic-prescribing
- Australian Digital Health Agency: www.digitalhealth.gov.au/get-started-with-digital-health/electronic-prescriptions
- Country SA PHN: www.countrysaphn.com.au/support/digital-health/

## GROWTH IN ELECTRONIC PRESCRIPTIONS IN SOUTH AUSTRALIA

| DATE | Number of ePrescriptions issued by prescribers | Number of prescribers who have issued ePrescriptions | Number of community pharmacies dispensing ePrescriptions |
|---|---|---|---|
| 18 November 2020 | 7,684 | 114 | 246 |
| 12 January 2021 | 42,366 | 555 | 500 |

# No one left behind

The AMA's advice, advocacy and intervention are instrumental in planning and managing Australia's delivery of COVID-19 vaccines, writes AMA Vice-President and AMA(SA) President Dr Chris Moy.

Australia's COVID-19 strategy is rapidly evolving as details firm – about developing scientific evidence and the practicalities of what is a massive undertaking to protect the Australian community.

The AMA has been a key player in advocating and intervening to ensure the strategy provides the best possible outcomes for public health and for doctors who must deal with the consequences.

As shown on p13, the Australian Government has entered four contracts for the supply of COVID-19 vaccines, should they be approved by the regulator. Some of the vaccines will be used to supply Australia's Pacific neighbours.

At the time of writing, the Pfizer vaccine had been provisionally approved for use in patients over 16 years, with the first round of vaccinations about to begin. The AstraZeneca vaccine had also just been approved by the independent regulator and it will be largely manufactured at the Commonwealth Serum Laboratories in Melbourne – hopefully bypassing emerging problems with global supply chains. A consulting firm was commissioned to analyse the potential for Australia to manufacture mRNA vaccines, and while there is some expertise in this space, it is not yet at a commercial level.

While attention has understandably been on vaccines – particularly as new variants emerge – the Prime Minister has reminded us all that the vaccination program will not be a substitute for the continuation of current COVID-19 precautions, and that being vaccinated will not mean that international travellers will not need to quarantine.

This is a project of unforeseen scale in this country. In some forums, I've likened it to Dunkirk – both in terms of size and in how many critical elements must be considered and addressed for us to be successful.

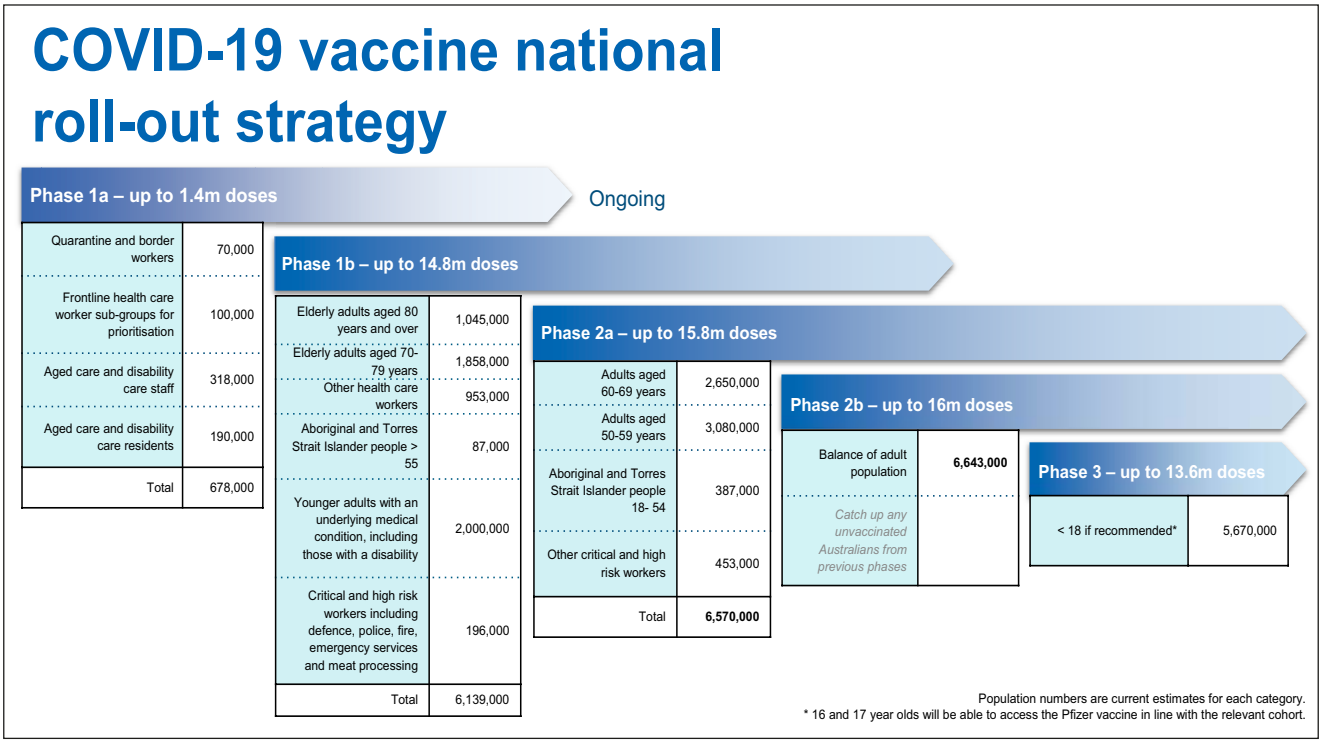
## INFECTION VS DISEASE PREVENTION

Given early fears that a vaccine against COVID-19 might never be developed, we should be relieved and thankful that a slew of safe and effective vaccines has already appeared, and others are being developed.

Beyond some debates about the relative 'efficacies' of the first two vaccines off the rank – the Pfizer/BioNTech and AstraZeneca (AZ) vaccines – the only clear evidence is that both are safe and are very good at stopping severe disease and death.

...Continued on page 13

*Continued from page 12 ...*




*Australia Government, February 2021*

As such, the current primary goal of the COVID-19 vaccination program is the protection of individuals from having to go to hospital and perhaps dying from the virus.

What is unclear is whether these vaccines can prevent asymptomatic infection or transmission. As a result, the goal of the current program is not attaining 'herd immunity', although this is a secondary aim and our capacity to achieve it will emerge with further scientific evidence.

Further unknowns are for how long these vaccines will be effective, and how emerging variants of COVID-19 will impact on their effectiveness. So, until we know more it is likely that the vaccine program may have to adjust and incorporate new vaccines, or booster shots of updated versions of the current ones, as we work towards maximal protection against an evolving virus.

## LOGISTICS

It's not the vaccine that will save us, but the vaccination of the majority of the community.

However, logistics associated with the vaccines, such as having to store the Pfizer vaccine at minus 70 degrees Celsius and large batch numbers, are playing a major part in the roll-out strategy. But because it was the first approved, the Pfizer vaccine will be the first one we see.

The Pfizer vaccine will be rolled out to the first group of about 600,000 Australians at high risk of being infected or serious disease. Given its storage requirements, it's primarily being rolled out through hospitals.

The AZ vaccine, a viral vector vaccine that can be stored in a standard freezer and comes in more manageable batch sizes, will be easier to deliver in the community and to more people. A vaccine developed by Novavax – a protein-based vaccine that will be manufactured in Australia – may be more widely used later as its transport and storage requirements are less onerous.

With changes to scientific evidence, we may end up with mixed regimes – say, with AZ first and then an mRNA or protein vaccine as a second dose or a booster later.

## SAFETY

So, the $1 million question – especially considering all the anti-vax sentiment, confusion and crack-pot science in the community: *are the vaccinations really safe?*

Australia has had the benefit of being able to watch and learn from overseas experiences, as first the clinical trials, and then large-scale deployments of the vaccines under emergency provisions, has occurred. The information from overseas has been positive, with no evidence yet of any significant safety issues, even those that were thought possible in the current vaccines.

For example, there have been concerns about mRNA vaccines and whether their genetic material could be incorporated into our genome. But we have two decades of experience with DNA vaccines and there has been no evidence of this so far.

In addition, concerns about the vaccines causing Guillain-Barre syndrome or antibody-dependent enhancement of disease have not been borne out, despite significant international experience.

## COMMUNITY ACCEPTANCE

The AMA will have an important role in encouraging community acceptance and overcoming lingering vaccine hesitancy. We've continually emphasised that we are an independent voice, focused on achieving the best possible outcomes for the health of our patients.

It is important that the AMA walks a careful line between asking the hard questions about issues such as which vaccine should be adopted or the practicalities of the roll-out and reassuring the public about the overall sense of the strategy and purpose in this effort to protect them.

*...Continued on page 14*

*Continued from page 13 ...*

We need strong, clear, consistent messaging. Just as the Prime Minister has been pressured to keep Craig Kelly in line because of the divisive nature of his false and inflammatory claims and statements, so must doctors stick together. It is important to build and maintain trust in the vaccine program in public, rather than reinforce inaccuracies or create distractions.

## PRIORITY GROUPS

The vaccine will be rolled out to priority groups first – those at greater risk of exposure or likely to have a more serious disease – and then sequentially in groups, with the overall aim to reduce risk.

Trials will have to be conducted on children and younger people before a vaccine is approved for paediatric use, as is the case with other vaccines developed for adults.

Children under five years who are more at risk of complications such as febrile convulsions are unlikely to receive a vaccine in the near future and are more likely to receive a protein-based vaccination (such as the Novavax), which is less reactogenic. Young people won't be negatively affected by the delay in vaccinating them because they tend not to be symptomatic or to have mild symptoms. However, this strategy will reduce the potential for herd immunity, as young people under 20 account for 25 per cent of the Australian population.

At the time of writing, the roll-out in Australia will look like this:

**Phase 1a**

- Quarantine and border workers
- Frontline health care workers
- Aged care and disability staff
- Aged care and disability residents

**Phase 1b**

- Adults over 80 years
- Adults 70-79
- Other health care workers
- Aboriginal and Torres Strait Islander people over 55
- Younger adults with an underlying medical condition, including those with a disability
- Critical and high-risk workers. including defence, police, fire, emergency services and meat processing

**Phase 2a**

- Adults aged 60-69 years
- Adults aged 50-59 years
- Aboriginal and Torres Strait Islander people 18-54
- Other critical and high-risk workers

**Phase 2b**

- Remaining adults
- Any missed from earlier phases

## SIDE EFFECTS

Reports from international jurisdictions, including the UK, suggest side effects are likely to be few. People may experience chills, fatigue and headaches. In clinical trials of both vaccines, mild to moderate side effects were common within a week of vaccination. Most side effects, however, usually occur within a day or two and go away in a few days.

An NHS study in the UK found few side effects in a study of about 40,000 people, most of whom were healthcare workers. The study found:

- 37 per cent of participants experienced some local 'after-effects', such as pain or swelling near the site of the injection, after their first dose, rising to about 45 per cent of the 10,000 who had received two doses
- 14 per cent had at least one whole-body (systemic) after-effect – such as fever, aches or chills – within seven days of the first dose, rising to about 22 per cent after the second dose.

People with a history of significant allergic reactions, rather than general allergies, have been advised not to have the mNRA Pfizer-BioNTech vaccine or the similar Moderna vaccine because of a small number of anaphylactoid reactions. Because the vaccine is not 'live', theoretically it can be given to immune-compromised people and pregnant women, and it will be, offered on a case-by-case basis.

## ADMINISTERING THE VACCINE

While pharmacists have campaigned to deliver the vaccine, the AMA has argued that the credibility of the program is boosted when the program is led by doctors. We have argued that it would be difficult for pharmacists to provide the vaccination in privacy and in a COVID-safe way; that it is important that the vaccine is delivered by people trained to manage potential risks associated with allergic reactions. How could pharmacists know a patient's history to assess whether and when they should get the vaccine?

In addition, there seem to be major barriers to pharmacy provision of the vaccine, including lack of privacy for discussions, difficulties in providing the vaccine in a COVID-safe manner in a busy pharmacy, and the ability to observe and properly respond post-vaccination. As I write this, largely due to AMA advocacy, the funding secured for distribution via Australia's GP practices is many times that being directed to pharmacies.

The AMA advocacy has also secured for GPs more after-hours and rural funding support, allowing appropriate co-claiming with other MBS items, and the provision of consumables and required PPE. The increased loading to support vaccination after hours was key to helping practices provide the vaccine while not upsetting the care of their patients in-hours.

## RECORDING, INDEMNITY AND SYSTEMS

The recording of vaccinations is critical to the roll-out strategy. The type and sequence of vaccinations must be recorded in the Australian Immunisation Register, and this requirement has now been enshrined in legislation. This will be crucial, particularly for individuals who will need proof of vaccination in the future.

The AMA has advocated for doctors to have the informed consent process reviewed by medical defence organisations (MDOs) and the Australian Health Practitioner Regulation Authority, and to fully address indemnity issues – although all major MDOs have confirmed they will cover doctors administering COVID-19 vaccines to their patients.

There are also questions about how to ensure the National Booking System will operate – for example, for less IT-literate patients and for those for whom English is not the primary language. At this stage, the proposal is that the National Booking System will comprise a one-stop shop website where a patient can obtain information about COVID-19 vaccination, determine their eligibility, and find a practice for service with which they will be able to book an appointment. However, there are complex issues to finalise, such as how patients can determine and confirm their eligibility based on medical conditions. And to prevent wastage, there must be accurate matching of the number of patients booked to the number of doses contained in each multi-dose vial.

## MY ELEVATOR PITCH

The COVID-19 vaccine roll-out is a hugely important undertaking for our patients and our communities. Australians are crying out for this protection and for their lives to get closer to normality. As doctors, it is a time to stand up, remember why we joined the profession, and get the job done for them.

# AMA highlights vaping harm

The AMA is encouraging limitations to Australians' access to vaping products.

Regulatory changes to close a loophole that allows people to access imported nicotine products for vaping without a prescription will come into effect from October 2021, amid evidence that young people are increasingly taking up e-cigarettes.

The Therapeutic Goods Administration (TGA) announced in December that imports of nicotine e-cigarettes and liquid nicotine for vaping will require a doctor's prescription, aligning with domestic laws.

It rectifies a regulatory twist through which consumers could import nicotine products, even though possession or use without a prescription is illegal in all states except South Australia and domestic sales are illegal.

The TGA scheduling delegate said, 'restrictions on the availability of e-cigarettes are necessary to mitigate the potential uptake of smoking in young adults who would otherwise be at low risk of initiating nicotine addiction'.

This responds to evidence that nicotine e-cigarettes act as a 'gateway' to smoking in youth, and that exposure to nicotine in adolescents may have long-term consequences for brain development.

The amendment to limit access to imported nicotine products by rescheduling it on the Poisons Standard aims to eliminate an 'ON RAMP' to nicotine addiction for non-smokers, while enabling smokers to legally access nicotine e-cigarettes to help them quit smoking – to provide the 'OFF RAMP' for smokers.

AMA President Dr Omar Khorshid said the AMA supported the amendment as an additional barrier to people taking up vaping. However, he said, concerns remain around characterising vaping as an effective smoking cessation tool.

'We do not have credible evidence to show that e-cigarettes and vaping are safe, or that they are effective as a cessation aid,' Dr Khorshid said. 'There is evidence to suggest vaping causes harm in brain development and can increase the risk of respiratory and cardiovascular disease.'

'At the moment, public discourse is focused on vaping as a smoking cessation tool but there is little discussion about the rising social uptake.'

In a media statement, Federal Health Minister Greg Hunt said there had been rapid growth in vaping uptake by young people around the world.

- Between 2016 and 2019, the number of current e-cigarette users in Australia aged 15-24 increased by 72,000, or 95.7 per cent, to reach 147,000.
- Recent Australian National University (ANU) research indicates e-cigarette users are three times more likely to take up traditional cigarette products as non-users.
- Between 2015 and 2019, e-cigarette usage by US youth increased by about 1.13 million young people aged 14-19 years (a 71.9 per cent increase). Around 4 million US high-school students use e-cigarettes.

Even vaping products without nicotine are considered potentially harmful. Flavoured vaping products are not illegal but contain harmful chemicals such as formaldehyde and other carcinogens and, disturbingly, despite the ban on nicotine in e-cigarettes, random sweep-studies of vaping products found nicotine in many.

'In the past, people did not realise the dangers of smoking. Everyone smoked in the car, they smoked inside,' Dr Khorshid said. 'There are some alarming similarities in the present day in terms of lack of public awareness. There's not a lot of understanding among people who don't vape about what is occurring and why it is appealing or how people access e-cigarettes.'

In its submission to the TGA review, the AMA noted that a recent ANU review of randomised controlled trials (RCTs) found e-cigarette use was not associated with a significant difference in quit rates, compared to other forms of smoking cessation assistance.

It also noted that people using nicotine vaping products to stop smoking were significantly more likely than people using other forms of nicotine-replacement therapies to continue using the products after one year.

'On the basis of the eight or so RCTs the review looked at, vaping was not found to be a more effective aid in smoking cessation than counselling and other forms of nicotine replacements such as patches, gums and nasal sprays,' Dr Khorshid said.

Under the new regulations, medical practitioners who consider nicotine e-cigarettes an appropriate treatment for a patient trying to quit smoking can prescribe them if they have approval through the TGA Access Pathways. This is because there are no TGA-approved nicotine vaping products. The medical practitioner does not have to apply if the patient is importing less than a three-month supply through the TGA Personal Importation Scheme. Nicotine e-cigarettes will also be dispensed from pharmacies.

Yet most medical practitioners are likely to support vaping as a quit-smoking tool only as a last resort.

'The amendment will mean that rather than having ready access to imported vaping products, patients will be required to discuss the whole range of treatments with their GP if they are seeking a vaping prescription. Some will not be willing to prescribe it at all,' Dr Khorshid said.

He said the TGA should consider additional regulations on the vaping products – as well as their use – to limit potential harms.

'It's important that people continue to be made aware of the potential harms of vaping,' he said. 'The new amendment means that rather than relying on anecdotal evidence or Dr Google, patients who are trying to quit smoking will have access to evidence-based advice about the most effective tools.'

# New research a watershed

South Australian research into breast cancer treatments may transform outcomes for women around the world.

*Professor Wayne Tilley, Associate Professor Theresa Hickey and Dr Stephen Birrell*

After more than 30 years of research, an international team led by researchers at the University of Adelaide has published paradigm-shifting evidence that will offer hope to metastatic breast cancer patients where standard treatment has failed.

It will also potentially improve their quality of life during treatment.

The paper in the prestigious journal *Nature Medicine* provides definitive preclinical evidence that stimulating androgen receptor activity is a better way of treating estrogen-receptor driven breast cancer (in 75 to 80 per cent of all cases) than the standard approach of inhibiting estrogen receptors. It also shows the treatment has positive rather than negative side effects.

The Dame Roma Mitchell Cancer Research Laboratories (DRMCRL) at the University of Adelaide collaborated with researchers the Garvan Institute of Medical Research in Sydney and overseas institutions to develop the compelling evidence required by *Nature Medicine* to end a long-standing debate about the role of the androgen receptor in breast cancer.

The team was led by DRMCRL director Professor Wayne Tilley, who cloned the human androgen receptor in the late 1980s at the University of Texas Southwestern Medical Center in Dallas; the head of the DRMCRL Breast Cancer Group, Associate Professor Theresa Hickey; and DRMCRL affiliate Dr Stephen Birrell, former director of the Breast Cancer Unit at Flinders Medical Centre and now chair of Adelaide-based HAVAH Therapeutics and Wellend Health.

The DRMCRL team says the finding is the type of light-bulb moment that occurred when Australian researcher and Nobel Laureate, Professor Barry Marshall swallowed the H. pylori bacteria to prove it caused stomach ulcers, debunking the prevailing wisdom that they were caused by acid build up.

'We could have published this research three to five years ago,' Professor Tilley says, 'but we wanted to publish in a high-impact journal such as *Nature Medicine*, which required generating compelling evidence that this strategy would work across the spectrum of ER-positive breast cancers.

'This required us to develop a range of contemporary preclinical breast cancer models using human tissues and interrogating these models with new genomic technologies.'

'By holding our nerve and producing definitive data in the *Nature Medicine* publication, including preclinical data in independent laboratories around the world using multiple models, we can now put to rest a lot of the arguments against using androgens in the treatment of breast cancer,' he says.

'We believe these findings will result in a seismic shift in how to exploit the androgen receptor in breast cancer using selective androgen receptor modulators that lack the virilising side effects of "male" hormones and are not metabolised to estrogen.

'It's uncommon to have this much reproducibility ... that's pretty extraordinary and I think that's why the scientific and medical community has embraced this as being an important step forward in developing a potential new hormone therapy to treat breast cancer.'

Researchers have long known that estrogen receptor-positive breast cancers also have androgen receptors. The DRMCRL research has provided new insight into the way androgen receptors work in the breast.

Professor Tilley says it's well understood that abnormal estrogen receptor activity can lead to cancer cells proliferating and surviving in the breast, just as abnormal androgen receptors do in the prostate. However, he says, confusion reigned about whether androgen receptors were a help or a hindrance in breast cancer treatment.

Androgens were historically used in treating breast cancers, but the mechanism was poorly understood and the treatment, based on naturally occurring androgens in men, was discontinued because it had masculinising side-effects. New estrogen receptor targeting drugs (that is, endocrine therapies) replaced androgens as the standard of care treatment.

The prevailing thinking around breast cancer treatment focused on inhibiting estrogen biosynthesis or blocking estrogen receptors. But, says Professor Tilley, although endocrine therapies have very good initial treatment responses, endocrine therapies are not curative. Not only do they fail to prevent breast cancer recurring in some women, but they can also have terrible side effects.

Most people do not appreciate that while the five-year survival rate for breast cancer has risen impressively

over the past 30 years, there is still much to be done to improve breast cancer outcomes, Professor Tilley says.

'In addition to needing alternative treatments for endocrine resistant disease, existing treatments often make women feel terrible – for example they may have severe joint pain. There's enormous work to be done to improve disease outcomes, both in terms of overall survival and the quality of life for a woman with breast cancer.'

Resistance to estrogen receptor targeted therapy is a major cause of breast cancer mortality, Professor Tilley says – that's why new strategies such as the androgen activation approach are needed.

Using cell-line (for comparative purposes) and new patient-derived models, the global team demonstrated that activating androgen receptors with natural androgen or a new selective androgen receptor activator (SARM) had potent anti-tumour activity. It worked in preclinical models of resistance to existing standard of care treatments. In contrast, inhibiting the androgen receptor had no effect.

Importantly, androgen receptor activation in breast cancer mimics what happens in a normal breast, effectively inhibiting estrogen-receptor activity.

'It literally took us five years to generate the contemporary models and associated genomic data for this study,' Professor Tilley explains. 'But without this type of definitive research, you only add to the confusion in the literature.'

The team used human tissues from patients who had multi-drug resistance, propagating samples for transplant in mice, then worked with independent laboratories around the world to ensure its findings were robust – all at considerable cost.

'We are pretty confident this is going to work in patients who have developed metastatic disease that is resistance to current endocrine therapies. That's really exciting because that's the lethal stage of breast cancer,' says Professor Tilley.

Professor Tilley admits it's been a long road since he and Dr Birrell first began working together with breast cancer surgeon and pioneer Dr Elizabeth Cant at Flinders Medical Centre in the 1990s.

The pair measured androgen and estrogen receptors in breast cancer biopsy samples over more than five years and showed a strong relationship between the level of the androgen receptor and response to an endocrine therapy. The research published in the Journal of Clinical Oncology in 1995 provided the first evidence that the androgen receptor had an important role in clinical breast cancer.

Despite great inroads into breast cancer research and treatment, the role of the androgen receptor remained under-researched and shrouded in prejudice – until now, Professor Tilley says.

It was not until new preclinical models and molecular methods were developed that the researchers could fully elucidate how the androgen receptor works in estrogen-receptor-positive breast cancer and that it needs to be activated rather than blocked to inhibit tumour growth.

Professor Tilley says there's considerable evidence that the new androgen treatment is safe – and that the side-effects are positive – for example, improving bone density, lean body mass and, potentially, cognitive function and libido. In addition, the potential for detrimental side-effects is reduced with the movement away from old testosterone-based androgens towards new androgen delivery systems and selective androgen receptor modulators (SARMs).

The next step is to undertake a Phase 3 registration trial in the US, initially on women with estrogen receptor driven breast cancer who have failed endocrine therapy and subsequently failed treatment with a CDK 4/6 inhibitor – an uphill battle for any treatment. Positive clinical results and the findings outlined in the *Nature Medicine* publication could fast-track this treatment to metastatic breast cancer treatment within three years.

'A spinoff from this research is that androgen receptor antagonists could be used in breast cancer prevention and benign conditions such as endometriosis and breast pain where there is a great need for better treatments – it is important that we establish this treatment for one condition and then it can expand to other estrogen-receptor driven diseases,' Professor Tilley says.

The *Nature Medicine* publication is also vital to help secure ongoing research funding, which he says is increasingly difficult to obtain.

For more information see New discovery in breast cancer treatment on YouTube or read *the article at* https://doi.org/10.1038/s41591-020-01168-7

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# The road to success

The easiest path is rarely the preferred one for 2021 Rhodes Scholar and AMA(SA) member Dr Sarah Short.

*South Australia's 2021 Rhodes Scholar Dr Sarah Short*

'A journey of one thousand miles starts with the first step', we're told. But, deep down, most of us understand that the first step on an epic journey is likely to lead us towards great personal challenges – so, that step is rarely easy.

And when you are working steadfastly towards a medical degree, it may seem difficult to take that first step as a detour into research, says Adelaide Medical School graduate and the University of Adelaide's 112th recipient of a Rhodes Scholarship, Dr Sarah Short.

Dr Short's quest for scientific discovery has been a slow burn, in keeping with the peripatetic path to study medicine in the first place.

'I definitely was not one of those people who grew up knowing that medicine is what I wanted to do. I was quite set on doing physiotherapy for a very long time. I did the UMAT (now the UCAT) just in case in year 12 and applied to both medicine and physio, and when I got into medicine, I decided to pursue that – it had a lot of the features I liked about physio but had more career options,' Dr Short recalls.

'It probably wasn't until fourth year that I really found something I was interested in: that was surgery, and plastics in particular.

'I never really thought I would be interested in research but did an Honours year and just found that incredible – the mix of clinical medicine and basic science. Now I'm really looking forward to pursuing research.'

Having worked with a team led by Professor Toby Coates at the University of Adelaide to improve outcomes for type 1 diabetes patients by transplanting insulin-producing islet cells, Dr Short became inspired by the opportunities to use innovations in basic science in clinical medicine.

The team explored surgical approaches to treating diabetes, combining plastic surgery and transplantation medicine, including transplanting islet cells created by a 3D printer.

'We looked at some of the issues associated with infusing islet cells into the liver, which is the traditional site, which prompted the team to look at alternative sites to transplant islet cells to improve outcomes,' Dr Short says. 'If the research is successful, it may mean the end of daily insulin injections for those with type 1 diabetes.

'The techniques can also be applied to other types of transplantation – for example, transplanting adrenal cells to treat adrenal insufficiency.'

Having seen how the basic sciences can be applied to help practitioners and patients prompted Dr Short to begin the gruelling application process for the Rhodes Scholarship.

'I was always aware of the Rhodes Scholarship but never thought I would end up doing a DPhil or research,' she says. 'I think it was only really once I started my Honours degree and found I enjoyed research so much that I started looking for opportunities to do that once I finished my medical degree.

'It is very tough to actually decide to apply for it. Talking to everyone who ended up at the interviews – everyone said, "I never thought I would be good enough to apply – I never thought I would be here". One of the hardest barriers is deciding to apply.'

True to the Rhodes Scholarship purpose to nurture 'leaders for the world's future', Dr Short intends using the platform to highlight how clinician scientists can conduct and promote transformational medicine in hospitals. She wants to explore how to translate basic science into new therapies for surgical patients, to improve outcomes and provide new therapeutic options.

COVID restrictions or no COVID restrictions, the 2021 Rhodes Scholars are expected to start at Oxford later this year. Dr Short will be working with the Director of Transplantation, Research and Immunology Group.

It's also about creating pathways for other young clinicians, she says.

'Ideally I would like to come back and have a role where you can do both research and clinical medicine. I think you are seeing the emergence now of a lot more roles that combine leading a research group within a hospital as well as managing clinical groups.

'Clinicians may bridge the gap between those basic science advances that you see in labs and actually translate them to the bedside so that they affect the patients. That's the area where scientist clinicians can make a really big difference.'

She foresees a future in which she and others with research backgrounds could establish research interest groups that motivate students and young clinicians to investigate those areas.

'Young doctors are often focused on their clinical training, and either don't have time for clinical research or pursue quite "easy" research that doesn't generate a large impact because it is seen as a quick way to tick off those research publication requirements for advanced training programs,' Dr Short says.

She says it is important to have flexibility within training programs – to encourage young doctors to take the hard road towards transformational research after an already arduous training program.

However, Dr Short recognises that not everyone is compelled to take on the toughest challenges. As a former artistic gymnast and now an elite triathlete, Dr Short laughingly admits she is one who is.

'In spite of myself, I don't follow the easy path. I always tell myself after I pick up a new thing that I will finish it off and calm down and try not to take on as much after that, but I've never been good at that.

'And triathlon is the worst sport to try to pick up while you're in med school, but I had to do that as well.'

# Orders of merit

Four AMA(SA) members were acknowledged with awards in January's Australia Day Honours List.

## Dr Roy Scragg AM OBE

A sliding door moment stood between Adelaide University graduate, Dr Roy Scragg, making a useful research contribution in Arnhem Land and becoming a pioneer of career epidemiologists in Australasia.

Offered a position to work as a doctor in Arnhem Land in 1947, Dr Scragg instead took up a position in Papua New Guinea after World War II, and in 1950 began a study to explore why the birth rate was declining in New Ireland.

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

Dr Scragg famously discovered that the declining population in New Ireland could be due to childlessness caused by gonorrhea. His work led to an Order of the British Empire for Public Service in 1970 and to his becoming a Member of the Order of Australia in 2021.

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

## Professor John Crompton AM

As an eminent ophthalmologist and former head of the neuro-ophthalmology service at the Royal Adelaide Hospital (1984-2017) and a member of the Army Reserves from 1965 to 2011, Professor John Crompton might have been busy enough.

But it was the joy of helping people in the Solomon Islands in the early 1980s that he says provided the greatest inspiration, earning him an Australia Day honour as a Member of the Order of Australia.

'You learn so much from these people. It's not all one way – you exchange ideas,' he says.

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

'If we bring people to do fellowships here, that country loses them for a year and we are teaching them on our patients, with our investigations and our treatments and it's not appropriate. We've learned that it is far better to do in-country fellowships,' he says.

## Dr John Willoughby OAM

Ophthalmologist, vigneron, winemaker, sailor, inventor and philanthropist Dr John Willoughby is, by his own account, always looking for a challenge.

Awarded the Medal of the Order of Australia for services in improving eyesight in the Pacific with his Vision of Islands charity, and for services to sailing as a regular skipper in the Sydney-Hobart yacht race, Dr Willoughby has devoted significant brainpower to each.

Dr Willoughby has almost lost count of the number of the cataract and laser surgeries performed in the 24 years he travelled to the Pacific Islands from his Gawler practice. Between 1996 and 2006 the team performed 500 cataract surgeries, 1,500 laser surgeries and donated 20,000 pairs of glasses.

His latest project is a bid to sail to the Pacific Islands.

'One of the greatest challenges has been taking in the equipment – you have to haggle about the baggage. And, of course, if we could quarantine on the yacht that would overcome difficulties around COVID restrictions,' Dr Willoughby says.

## Dr David Hamilton OAM

Surgeon David Hamilton well remembers being inducted into what was then the British Medical Association (now the AMA(SA)) in 1958.

'I was so proud – I'd come through as a humble medical student and suddenly I was a member of the BMA and people were calling me "doctor". I always have been very proud of my membership,' Dr Hamilton says.

It was that pride in the profession that drove Dr Hamilton to contribute to the association and its committees and earn him the Medal of the Order of Australia in 2021.

Issues such as the move to downgrade the Modbury Hospital to a non-teaching hospital have kept that fire burning well into his 80s. 'Modbury Hospital was a very good general teaching hospital. Students all loved it. [The government] trashed it when they made it just for day cases. You can't run a proper teaching hospital with that sort of system – that sort of thing got me fired up,' he says.

'The AMA is the number one organisation representing doctors. It is my belief that every doctor should be a member. It's great to see that many of my trainees have become some of South Australia's leading surgeons... I'm so happy with my profession.'

# Eating disorders still a mystery

Eating disorder treatment is most successful when the disease is identified early – and that relies on general practitioners being ready to consider them as the cause of a range of physical and mental health symptoms.

Eating disorders have typically been seen to be driven by one of two things: a dysfunctional family or vanity. They're regarded as a 'first-world problem' of mainly white, high-socioeconomic teenaged girls.

Yet South Australia's leading experts in eating disorders tell families that the disorders affect people across the age, gender, socio-economic and cultural spectrums – and that it is a very serious disease.

Children with leukaemia have a better chance of recovery (around 90 per cent) than a child presenting with an eating disorder.

'It's a very serious, complex disease with a high death rate through complications such as heart failure or from suicide. Even with the best evidence-based treatment, the rate of recovery is only 60 to 80 per cent,' says the Clinical Lead for the Flinders Medical Centre (FMC) Paediatric Eating Disorder Team, Dr Mandy Yiu.

Eating disorders and disordered eating includes anorexia nervosa (the restrictive/binge purge type), bulimia nervosa, binge eating disorder, avoidant restrictive feeding eating disorder (ARFID) and excessive exercising. Together, they are known to affect around 9 per cent of the Australian population.[1] Some epidemiological studies suggest the figure may be as high as 16 per cent of the population.[2]

It's often recognised in adolescents (15-16 years) although it may have started much earlier (12-14 years) and many retain an eating disorder for life – often as a guilty secret. While there was little public discussion of it until the 1970s, reports of eating disorders date back to the Middle Ages.

And the rate of eating disorders is believed to be increasing, exacerbated by COVID-19 lockdowns which caused a rise in calls to the Eating Disorders Support Network (EndED) between February and July 2020.[3] That's why South Australia's plans for a State-wide Paediatric Eating Disorder Service and additional training of 'family-based treatment' (FBT) clinicians and therapists cannot be implemented quickly enough, says Dr Yiu.

Patients need easy access to a central expert eating disorder service to receive rapid assessment and treatment planning and the new statewide service is to be a gateway, bringing together Medicare-funded therapy, GP care and rapid lifesaving medical stabilisation for the most vulnerable patients - particularly those aged 16-18. More clinicians trained in FBT will be needed to support it.

The FMC's Paediatric Eating Disorder Unit, partnered with the Child & Adolescent Mental Health service, has made significant progress in reducing the number of admissions and re-admissions through the introduction of evidence-based family-based treatment (FBT) - the Maudsley or Westmead model.

The therapy requires a family to take control of their child's recovery through an outpatient re-feeding treatment model. Clinicians explain that food is the child's medicine and so families must administer every dose, just as they might manage chemotherapy treatments if they were dealing with cancer.

'We need a lot more training for FBT therapists and for GPs who are often the first port of call,' Dr Yiu says. 'There is some informal training, but I don't know how much there is in the undergraduate program.

'Even with paediatricians in training we have only just started to introduce it in the past couple of years, so we are very much behind in education.'

She says early detection and treatment are vital to prevent a chronic cycle of re-admission to hospital. Yet even in the medical profession, questions about the disease remain.

'There is still a delay in diagnosis, especially for those we call "atypical anorexia nervosa" where the young person is within a normal weight range for age and height or even slightly overweight but have experienced dramatic weight loss. They may have weighed 80 kg but lost 20 kg quickly and can have eating disorder behaviours.

'They can be medically unstable with bradycardia, postural tachycardia, cold intolerance, dizziness and fainting but are still in a "healthy weight range". This can be very deceiving.'

Dr Yiu says many GPs are unaware of the need for families to control the eating disorder patient's eating – yet without appropriate FBT support, patients face recurrent medical complications and hospital admissions.

Re-feeding needs to be rapid and requires high calorie foods to repair the starvation damage.

'People think parents should not be "force feeding" this is such a serious life-threatening illness, nutrition is the only way to recovery,' she says.

'Parents need to take control of all aspects of eating – what is eaten, the preparation of a highly nutritious meal, and supervising and encouraging until all the food is eaten. Parents supporting their child to eat is the cornerstone of FBT, because we know early weight restoration is critical.'

FMC Paediatric Eating Disorders Unit nurse consultant Sandy Bridgland says the pivot to FBT had transformed outcomes for patients, dramatically reducing re-admissions. The re-admission rate has reduced by 80 - 85 per cent since FBT was introduced at FMC in 2013 and the total number of admissions has declined from 69 to 44.

Previously, the psychological drivers of the disease were treated first. Patients who appeared medically unstable were admitted to hospital for tube feeding and then released, with most quickly resuming eating disorder behaviours and being readmitted to hospital.

'There was no understanding about eating disorders and the difficulties in treating them or for the families living with them,' Mrs Brigland says.

'There's lots of stigma attached to eating disorders. But it's an illness, not a personality trait or intentional stubbornness. It's very secretive; often people with eating disorders are in denial about it or feel shame and they will go to great lengths to hide their behaviour.'

The latest research indicates the disease is primarily a neuro-biochemical disorder, with about 40 to 60 per cent of the risk linked to genetic factors.

Mrs Bridgland says eating disorders often begin with a desire 'to be healthy'. A young person will reduce or eliminate sugars and fats, and stop eating junk food. They will then start to exercise.

When weight loss is noticed and praised, they may be encouraged to continue not eating, leading to further weight loss or, in children and teenagers, no expected growth.

While a common response is for people to say 'just eat', she says, research has shown that sudden weight loss causes chemical changes in the brain that trigger an eating disorder, preventing the person from eating.

For example, the 1950 Minnesota Semi-starvation study of 36 male volunteers showed semi-starvation precipitated eating disorder behaviour such as an obsession with food, bingeing, purging, toying with food and body image concerns.

The latest evidence demonstrates that the best way to treat eating disorders is with adequate food. FBT encourages families to see the eating disorder as a captor.

'The young person has a bully in their head driving their behaviours and they are unable to fight against it. They don't understand what is happening to them, they just know if they don't eat the "voice" in their head will quieten down,' Mrs Brigland says.

'Eating disorders affect almost every major system in the body. If your child has been malnourished for a long period of time, growth can slow down or even stop and they may be stunted in their physical and emotional development.

'We know that once we get them more nourished, their depression and anxiety often reduces and even goes away – food is their medicine.

'We need GPs to have the illness on their radar as it's often missed. Young people might present with things like abdominal pain, cold intolerance, cold peripheries, constipation or they might feel sick all the time and can't eat with the family. They might make excuses for not eating or might have lost their periods. We need the GP to think, "could this be an eating disorder?".

'People don't really understand it – they see a difficult teenager who is refusing to engage with treatment or their parents. But this is an illness we can fix if it is treated properly.'

[1]*National Eating Disorders Collaboration, National Practice Standards for Eating Disorders, 2020,* https://nedc.com.au/assets/NEDC-PRACTICE-STANDARDS-final.pdf

[2]*Hay, P., Girosi, F. & Mond, J. Prevalence and sociodemographic correlates of DSM-5 eating disorders in the Australian population.* J Eat Disord *3, 19 (2015).* https://doi.org/10.1186/s40337-015-0056-0

[3]*S. Rafferty, ABC Sunshine Coast, Impact of Coronavirus on People with Eating Disorders to be Studied as Calls for Support Rise, 8 July 2020,* https://www.abc.net.au/news/2020-07-08/eating-disorder-coronavirus-impact-to-be-studied/12428560

# 'Never panic' was doctor's first rule

Dr Peter Edgeworth Lillie passed away peacefully on the 21 January 2021, following a long and distinguished career in anaesthesia.

Friends and colleagues have recently had many opportunities to recognise and honour Dr Lillie. In 2019 he celebrated his 70th birthday and was made a Member in the General Division of the Order of Australia (AM) for his service to medicine in the field of anaesthesia. In 2020 he retired from Flinders Medical Centre (FMC) after 40 years of dedicated service and received an ANZCA Citation acknowledging him as an outstanding person, clinician and leader.

Dr Lillie started as a staff specialist at FMC in 1980 and in 2001 was appointed Director of the Department of Anaesthesia and Pain Management, a position he held until his retirement. During his tenure at FMC, he expanded the department to more than four times its original size, managed the amalgamation of the Repatriation General Hospital and implemented SA Health's 'Transforming Health' program. Always embracing progress in anaesthesia, he was quick to adopt innovations such as transoesophageal echocardiogram in cardiothoracics and the perioperative surgical pathways. He fostered inclusive, flexible and fair workplace practices, including gender equity in the hiring of staff, long before this was the norm.

A committed teacher, Dr Lillie served as an ANZCA examiner from 1988-2000 and was a coordinator and teacher on the Adelaide Primary Examination Course. He was a speaker on many international courses and heavily involved in teaching nursing and medical students at Flinders University. (It's not clear how widely he taught his golden rules of anaesthesia: 1. Never panic. 2. Don't F*^k it up 3. If you break rule 2 refer immediately to rule 1!)

Dr Lillie was a great contributor to the Australian Society of Anaesthetists (ASA), serving as its Federal Treasurer from 1988 to 2003, and receiving the President's Award in 1993 and Life Membership – the ASA's most significant award – in 2004. He also served as Chair of the South Australian Directors of Anaesthesia for 20 years and was a great advocate for anaesthetists and the specialty.

Many have described Peter not only as their colleague and mentor, but also as a trusted friend who provided them with support and guidance during both professional and personal challenges.

*Dr Peter Lillie*

He built not only a large anaesthesia department, but one that has become like a family to many.

Peter was forever calm in a crisis and handled every situation with expert skill, both in the operating theatre and in his administrative duties. His proficiency and knowledge of anaesthesia are beyond doubt, however it was his warmth and dry sense of humour which ensured that there was never a dull moment when he was at work.

*Dr Brigid Brown and*
*Dr Sophia Bermingham*
*Chair and Vice Chair of ASA SA/NT Committee and Consultant Anaesthetists at Flinders Medical Centre*

# On the record

AMA(SA) President Dr Chris Moy has been a national leader in developing and promoting My Health Record, the electronic 'filing system' of Australians' individual health histories. In a 'This Pathological Life' podcast with AMA member Dr Travis Brown and Steve Davis released this month, he explained the system's status and progress.

*Radio interviewer and podcaster Steve Davis and (seated) Dr Travis Brown*

**Steve Davis (SD):** There are about 23 million records as part of My Health Record. But as of last year, there was a report that about half of them remained empty. What's your assessment of its progress?

**Dr Chris Moy (CM):** While it has been around for 10 years or so, really the start date was when opt-out came in. Opt-out led to absolutely reasonable debates about privacy and the development of good legislation to support My Health Record.

It was always going to be something where you need to get enough people on board. Prior to opt-out, it was very difficult to get people to get involved, because there weren't enough people enrolling, and that was the whole point of opt-out. It was always going to be a slow buildup. Because for many of these things, you do need to keep on building the connections, the people building trust in it, getting used to it. And then after a while, you do hit this critical mass, where doctors think, 'gee, this is really useful. I've found something that would've taken me hours to find out, and I may not have been able to find out, about somebody who helped me treating this individual in front of me'. Or that the patient goes, 'I've actually got some information about myself that I can carry and I have greater empowerment about my own health'.

**SD:** I suppose the thing about opt-out, if we think about how we operate in this world, where we've got privacy agreements with every app we download that we ignore and just say yes.

**CM:** A lot of the discussions have been about the privacy aspect (but) it's a matter of being able to control your own privacy, which My Health Record allows. There's nothing quite like it where you can actually set your own standards, you can opt out, you can put pin numbers on there to control your whole file or individual documents or remove documents.

The irony is that (before My Health Record) a lot of people had been wondering why (for example) the hospital hasn't been able to get information that was in my computer about their allergies and their medications. And they think it's insane that we haven't had this. In fact, they assumed that was the case.

So, we can look at it one way, which is that everything should be in a box and private and nobody should ever be able to get it. But that's people applying their own values onto it. I look at it the other way and say a lot of people have expected us to be able to do this, and My Health Record was always a bridge to try and break down the fact that we are in silos, in terms of information.

**SD:** Yes, for me, the decision was based on imagining being on the gurney, being wheeled into an ambulance and then into a hospital – I don't want any seconds to be lost in getting information that could be used to save me.

**CM:** My background in advanced care directives (ACD) was important. An ACD is writing down what your wishes are or indicating who will make decisions for you when you can no longer make decisions. You can have all these documents that are absolutely useless unless they can be available at the point of care. For example, if your decision is that you don't want resuscitation because that's not something that fits with your view of life because you're near end-of-life. And my world is in aged care where I know a lot of patients have decided they don't want to go down that path, but when they enter the health system, it happens to them, with the absence of that information available. It's a complete travesty. And that drove me.

But the thing that really got to me later was when I understood, having worked in emergency departments, that frankly how we were doing it with no information in such a dangerous way, and we were providing care with no knowledge about whether somebody had an allergy to something or whether they had a contraindication because of a condition.

The thing that really sewed it up for me was I was looking after my sister-in-law, who was in hospital, and unfortunately developed such severe sepsis she lost her legs. She had a near death experience.

She's okay now. But I remember sitting with the emergency doctor and saying, 'what information did you have about allergies.' Because I knew about a penicillin allergy. And they said, 'nothing'. And if you think about the insanity of this world, where I knew that the difference between life and death was (that) she got lucky with the antibiotics that she was given.

Now, with My Health Record, it's got bank-level security. There's never been a breach of it. A lot of privacy advocates, I think, go completely overboard with it, imposing their personal values and privacy. In fact, sometimes doctors are doing that but my 90-year-old patient doesn't really care about their privacy, they just want safety in information and better health. And they want the hospital to know this information.

**SD:** Wow. So, this information has the ability to be an advocate then, to be that sense of security for those people at the frontline. The analogy I'm picturing here is that back in the day, when we were with one GP for life, that GP would carry that information in their head, and that this doesn't happen these days. So this

is like an outsourcing of that into some central repository, so we get some of the benefits of the doctor already knowing, which is held in this My Health Record. Is that a fair analogy?

**CM:** Yeah. And it's a tool, it's no more than an extra tool to try and improve the access to critical information about a patient, which can improve their health care and potentially actually improve their self-determination. Such as the advanced care directives being available. It has the very same documents that are already out there. It's just that at the moment they're stuck in my computer at home and can't be accessed. For somebody who really wants it, and it has health care as their priority, in fact, you're actually undermining their health, by not making it available.

**SD:** To be fair, what would be the weaknesses that you see at the moment in the system?

**CM:** I'm very big on making it as functional as possible. If it isn't slick, it's going to add time and weight and problems for me. That is a legitimate argument. Some of that is actually because of the legislation, to some degree. But some of it's just because, as most things, software changes over time. And also because in Australia, you have the My Health Record, which is infrastructure, which is created and controlled by the government. But you have on the other side of things, a lot of private vendors who have to tailor their links into My Health Record. And the way they make it look can vary a lot through the systems. And sometimes it's really great and sometimes it's not as great. And it does need to keep on evolving over time.

*In the* This Pathological Life *podcast series, Clinpath Pathology general pathologist Dr Travis Brown and podcast host Steve Davis share the history of diseases and place health challenges into social and professional contexts. To hear the whole interview and other podcasts, go to the Clinpath website.*

# New framework for vexatious notifications

The AMA understands how intensely distressing receiving a notification from the Australian Health Practitioner Regulation Agency (AHPRA) is to every medical professional, writes Dr Chris Moy.

The issue of vexatious complaints is one of the AMA's key areas of advocacy at national and state levels, and something we focus on every year.

In response to the AMA's calls, Ahpra released a framework to support the identification and management of vexatious notifications in December 2020, hopefully taking another step forward to improve their processes. The framework has been a long time in development and stems from two Senate reports into the medical complaints process in Australia and the complaints mechanism administered under the Health Practitioner Regulation National Law.

One of the key issues identified in evidence to these inquiries was that of vexatious complaints. Many health practitioners argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment, including by other health practitioners.

In its submission to the second inquiry the AMA called for the Ahpra complaints handling mechanisms to be improved by developing a system to triage and remove complaints that are clearly vexatious.

This evidence led to the Senate recommending that Ahpra and the national boards develop and publish a framework for identifying and dealing with vexatious complaints.

In 2018 Ahpra published a research report, Reducing, identifying and managing vexatious complaints, that was the first international literature review of vexatious complaints in health practitioner regulation. The report found that the number of vexatious complaints in Australia and internationally is small, representing less than 1 per cent, but concluded that these complaints have a significant impact on practitioners' lives.

The AMA continued to raise this issue with Ahpra and the Medical Board, urging further action be taken to enable vexatious complaints to be identified and managed earlier in the notification process thereby reducing harm to the practitioner.

Following detailed consultation with the AMA in the second half of 2020, Ahpra released its new framework to support the identification and management of vexatious notifications. This framework outlines:

- principles and features of vexatious notifications
- the significant impacts of vexatious notifications
- potential indicators of vexatious notifications
- how to identify vexatious notifications
- what to do where there is a concern that a notification is vexatious.

*Dr Chris Moy*

At the urging of the AMA, the framework also reinforces that health practitioners should not make vexatious complaints about other health practitioners. Vexatious notifications made by a registered health practitioner with the intent of harming another practitioner are taken seriously. A Board can take action against a practitioner who makes a vexatious notification about another health practitioner. This includes investigating the practitioner and, where vexatiousness is apparent, taking action that could affect the practitioner's registration. Vexatious notifications do not have good faith protections under the National Law.

# AMA Mortgage Broking puts YOU first

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

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

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

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

### Sweet Start

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

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

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

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

## Hello Racheal!

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



*Cashback Offer T&C's
1. AMA members are eligible for a cashback per application successfully settled during the promotional period.
2. Promotional period – The loan is lodged and settled between 4 November 2020 and 31 December 2021.
3. AMA members are entitled to receive the AMA cashback in addition to any bank/lender cashback offers (if eligible).
4. AMA Members will be eligible to a cashback on any loans successfully settled during the promotional period as per the below schedule under the following conditions:
5. Net loan value up to $750,000 receive $500 cashback
6. Net loan value $750,001 – $1,500,00 receive $1,000 cashback
7. Net loan value above $1,500,000 receive $2,000 cashback
8. The net loan value used to calculate the cashback is calculated after considering any offset balances or redraw facilities, as AMA Finance Brokers receives their share of commission after the aggregator/licensee split on the net loan amount.
9. The eligible cashback is calculated on total consolidated loan value per loan settled.
10. The eligible cashback will be paid within 6 weeks from the date of successful settlement by AMA Finance Brokers directly to the member's nominated bank account only.

**Dr Penny Need**
Ordinary Member
AMA(SA) Council

## AMA(SA) Council Meeting February 2021

The COVID-19 vaccination roll-out dominated the first AMA(SA) Council meeting for 2021. Chair Dr Michelle Atchison started the meeting with an acknowledgement of country in Kaurna language. Participating members were joined by observers Dr Guy Christie-Taylor, a member of the AMA(SA) Executive board; Dr Brian Peat; and Dr Cathrin Parsch. Drs Peat and Parsch were subsequently elected to fill the casual vacancies for Obstetrics and Gynaecology and Emergency Medicine respectively. They were warmly welcomed onto Council, as were the new student representatives for 2021, Mr Emerson Krstic from Flinders University, and Ms Shehani Gunasekera from the University of Adelaide.

The Australian COVID vaccination strategy will focus on preventing serious illness, hospitalisation and death in individuals. AMA(SA) President (and AMA Vice-President) Dr Chris Moy has been heavily involved in discussions at a federal and state level. Councillor Dr Patrick Quinn helped Dr Moy explain to Council issues and considerations around efficacy and vaccine safety. Mandatory vaccination and ethical concerns were discussed. It was noted that general practice will be a key component of the vaccination program. Negotiations are ongoing in regards to co-billing, expedited provider numbers for doctors in vaccination centres, and patient observation times.

The need for ongoing engagement with the medical workforce in relation to the new Women's and Children's hospital was highlighted. Dr Clair Pridmore and Dr Quinn were invited to join the next regular meeting of AMA(SA) and Health and Wellbeing Minister Stephen Wade.

Drs Moy and Samantha Mead have been working on the industrial contract negotiations for rural doctors working in local hospitals, aiming to ensure contracts are fit for purpose. Dr John Williams from Port Lincoln discussed the decline in the number of GPs in the area and that with great regret they have withdrawn services to the hospital.

An update on the progress of the Termination of Pregnancy Bill 2020 was provided. The AMA has aligned with RANZCOG and the Law Society on this women's health issue.

Dr Simon Lockwood raised concerns about some of the recommendations made by the Counsel Assisting the Aged Care Royal Commission, particularly the need for accreditation to be involved in aged care.

The Council voted to approve the use of the AMA logo on a Quit Your Way in May anti-smoking campaign.

The AMA(SA) Gala Dinner will be held on 22 May at the Adelaide Town Hall. Come along!

# 2020 University of Adelaide MBBS Graduates

AMA(SA) members congratulate the 2020 graduates of the Adelaide Medical School. We offer each of you our best wishes for your career and your life in this most important profession.

Haidar Hadri Abd Wahab
Matheesh Abeyratne
Lucinda Adams
Hubib Ahmad
Anton Alvaro
Wei Ang
Adon Asahina
Larissa Au
Nor Hidayati Awang Ahmad
Evelyn Axelby
Michael Bai
Andrew Baker
Emily Balfour
Tristan Bampton
Krishna Bayley
Fraser Betley
Ameya Bhanushali
Diba Bimal Gujari
Chloe Borgas
Sibella Breidahl
Chelsea Burford
Natasya Elena Cahyadi
Nicholas Chan
Joel Ern Zher Chan
Weijie Brandon Chang
Jennifer Chataway
Hui Min Chew
Ju Siang Chok
Cher Lynn Chong
Joycelyn Sze Ern Chong
Jonathan Chou
Hor Kit Choy
Brayden Claridge
Georgina Collins
Malage Dona Dissanayake
John Dongas
Dimitra Dounas
Sagar Elangovan
Jessica Farrar
Yu Heng Fong
Sarah Frost
Jessica Garland
Shaun Gerschwitz
Sze Wai Goh
Sylvia Gralak
Naomali Gunaratna
Emily Hammond
Sara Hariz
Craig Hatchwell
Lucienne Heath
Nimaya Hewage
Lucy Heyworth
Rebecca Hogan
Wee Jay Hoh
Florence Holland
Benjamin Peter Holz
Isabella Huang
Kaidan Huang
Jennifer Hughes
Jessica Huynh
Sarah Jones
Esther Jones
Kate Joyce
Portia Joyce-Tubb
James Kieu
Soravee Kiranantawat
Guo Hui Koh
Jing Ning Koh
Kevin Kour
George Koutouzis
Adina La Forgia
Katherine Lee
Ray Li
Xinlun Lim
Yi Joo Lim
Chia Ling Lim
Joss Lines
Joel Yu Xuan Ling
Long Tin Lo
Fergus Lynch
James Macadam
Carmelo Macri
Rose Massolino
Collette Massy-Westropp
Brendan McInerney
Bianca Melzner
Bonny Miller
Sarah Miller
Jessica Mitchell
Tanveer Mokha
Catalina Moraga Masson
Sean Zhong Jin Neo
Josephine Newbery
Li Sa Ng
Thu Nguyen
David Nguyen
Nicole Niu
Darcy Noll
Riley Ovan
Aayush Patel
Samuel Pears
Jade Pisaniello
Xiang Yuen Po
Roberta Potamianos
Mary Premnath
Charlotte Proudman
Qetada Rana
Bhuvanesh Ravichandran
Tenayah Renshaw
Joanna Richards
Madeleine Rock
Brigette Rodda
Emma Rose
Jake Rowe
Jack Rumbelow
Daniel Sansome
Hugh Schievenin
Eleanor Schofield
Julia Scott
Dilan Seimon
Imogen Sellars
Snezana Semak
Sharanya Shantharam
Kathryn Sharley
Sarah Short
Gurfarmaan Singh
Georgia Smithson-Tomas
John Snow
Leonard Tam Song
Fellicia Emily Stanzah
Peter Stapleton
Matthew Steen
Natasha Stolz
Brandon Stretton
Natalie Hui Tan
Westcott Wei-Ming Tan
Chong Tat Tan
Qing Xi Tan
Si Ying Adelle Tang
Sally Terrett
Vy Tran
Sarah Trewren
Timothy Trewren
Ashley Twigger
Eloise Vaughan
Vigneshwar Venkatesh
Janine Vu
Mary Wang
Isabella Watts
Weerakkody
Mudiyanselage Udani
Weerakkody
George Wells
Samuel West
Dasith Wewegama
Laura White
James Whitehead
Piyanit Wijaithum
Caleb Wijesinha
Millie Williams
Libo Xiong
Daniel Zweck

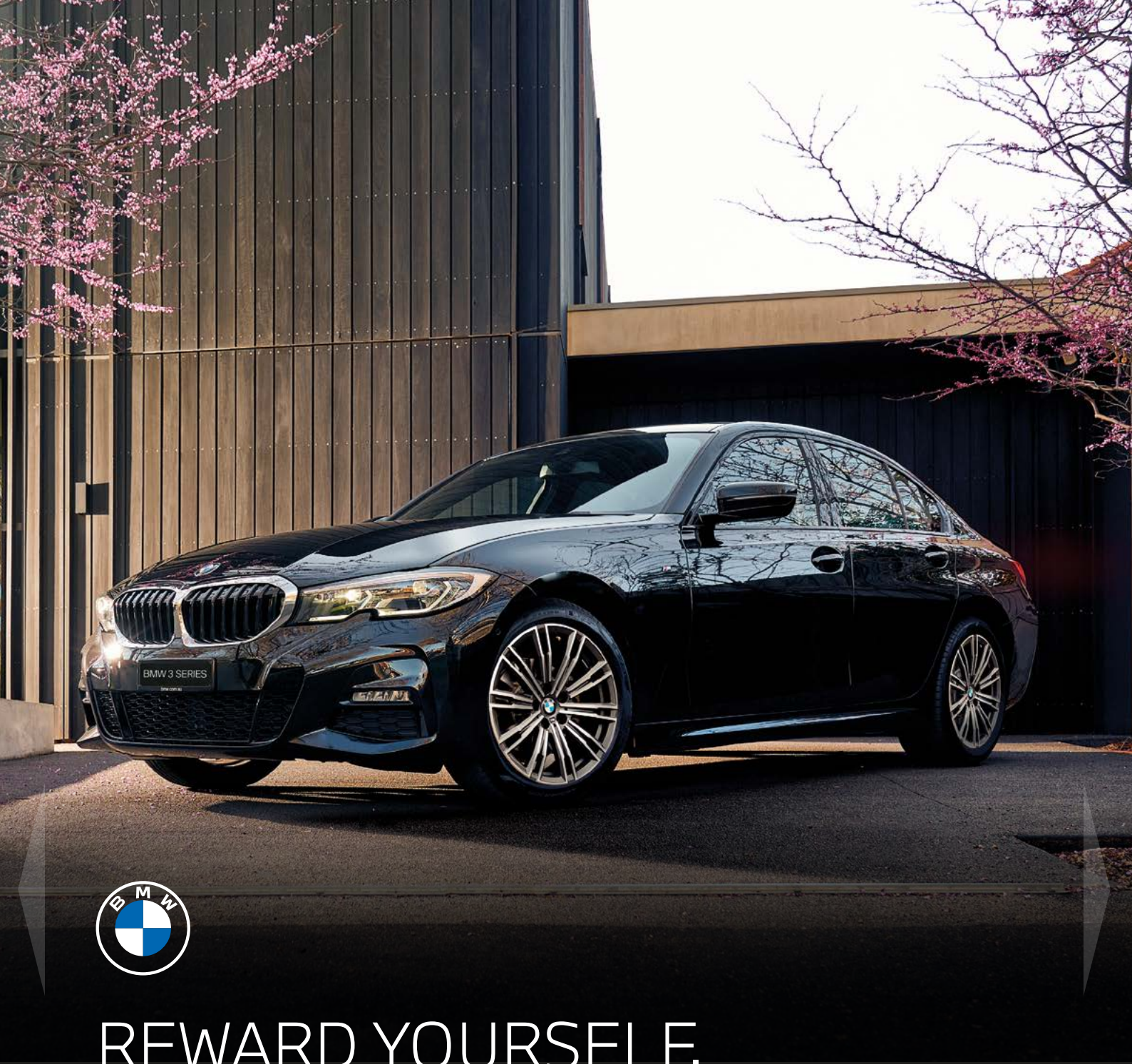
*The pandemic has delayed the University of Adelaide AMA(SA) Student Medal presentation.*

# 2020 Flinders University MD/BMBS Graduates

AMA(SA) members congratulate the 2020 graduates of the Flinders Medical School. We offer each of you our best wishes for your career and your life in this most important profession.

*AMA(SA) President Dr Chris Moy with joint AMA(SA) Student Prize winners Liam Ramsey (left) and (right) Matilda Smale*

Evangeline Allcroft
Lucas Allen
Reid Amos
Fang Ling Ivy Ang
Anita Atkinson
Wintnie Aung
Bronwyn Beelders
Harrison Bolt
Aliyah Bonnici
Mikaela Borgas
Andrew Burgan
James Burgess
Shan Jin Chang
Alicia Chua
Ellie Cobiac
Eloise Crawshaw
Roland Deek
Julian Di Ubaldo
Andrew Down
Aaron Foo
Melanie Forster
Hayden Frances
Lachlan Frost
Pamela Gebrehiwot
Claire Gibbs
Isabelle Gill
James Greenhalgh
Delu Gunasekera
David Harvey
Lara Hawkins
Isaac Hays
Jarryd Herd
Lewis Hewton
Sarah Howson
Kevin Hu
Yuemeng Huang
James Hughes
Kalyani Huilgol
Rebecca Jury
Nisha Kapetas
Garima Kapoor
Lily Kent
Catherine Keogh
Aafreen Khalid
Mungung Kim
Abbey Knox
Andrew Zhi-Yu Lai
Anthea Lambrakis
Imogen Lee
Si Yi Lee
Ther Lim
Alannah Luck
Nhi Mai
Rahul Malhotra
Jacinta Mangiameli
Kathryn Mau
Shade McClymont
Connor McPhail
Taylor Miell
Tracy Miller
Chulawallai Murray
Borivoje Nadlacki
Drina Ting Fang Ng
Nicholas Wei Jie Ng
Claris Hui Qi Oh
Zhong Ren Ong
Adam Overwheel
Hangju Park
Nikki Pennifold
Jospia Petric
Sima Rafaat
Dylan Raftery
Liam Ramsey
Maxine Resnekov
Hariti Saluja
Lauren Saw
Claire Schwerdtfeger
Yi Gim Jolyn Seah
W Rashmi Chanika Sirisena
Matilda Smale
Wei Liang Soo
Nadiah Banu Tadjoudine
Ethan Ly Ang Tang
Joshua Te
Laurence Trahair
Shivani Valunj
Stephanie Webster
Jonathan Weston
David White
Kristopher Wilckens
Katie Willson
Keren Wu
Ke Michelle Xu
Victoria Hu Neng Yeo
Jonar Zareh
Mengqi (Adele) Zhou

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# Children await suitable COVID-19 jab

The safety and efficacy of COVID-19 vaccines for children is among the issues to be addressed during planning for a universal roll-out.

Children and young people under the age of 16 are unlikely to be vaccinated for COVID-19 until more data is available about the vaccines' potential effects, says paediatric allergist and immunologist at the University of Adelaide, Professor Mike Gold.

Professor Gold says vaccines licensed for use in other countries reduce the severity of the disease, but children tend to be asymptomatic or only have mild COVID-19 symptoms. He says it makes sense to start with the elderly or those with comorbidities who are more vulnerable.

'There's some early evidence that the AstraZeneca vaccine may alter transmission, but we will need to wait a bit longer for evidence to know for certain – so at the moment the main aim of vaccination is similar to as it was for lockdown and all the other measures: to prevent mortality and the hospitals from being overrun,' Professor Gold says.

'Things are different here in Australia, as compared with countries like the US and the UK, because we've got low rates of infection and disease. Even at the height of the first wave in Australia few children were known to be infected and these were not the main source of transmission.'

Australia is planning a multi-pronged approach to vaccines with four vaccine supplies being secured:

- a Pfizer vaccine using new mRNA technology rolled out first. It has logistical challenges including the need to store below minus 70 degrees Celsius.
- an Oxford-AstraZeneca, viral vector vaccine, being rolled out second and to be manufactured in Australia.
- a Novavax, protein-based vaccine, rolled out later in 2021. It's more complicated to manufacture but more like the flu vaccine.
- COVAX Facility vaccines using various technologies, in an international venture to access a range of vaccine supplies.

The Pfizer vaccine has been provisionally approved by the Therapeutic Goods Administration and is being rolled out for those most at risk of transmission or likely to be significantly affected by the disease.

The Australian Government has advised that a key focus of the vaccination strategy is to ensure broad coverage of the population to mitigate its effects, ultimately enabling health authorities to manage the disease.

'In terms of introducing the vaccine into the adolescent and childhood population... the issue is really in younger children who are under five – here, the risk profile for some of the vaccines could be different,' he says.

'The mRNA vaccines (Pfizer and Moderna) are reactogenic and cause high fever so we would be concerned about febrile seizures in this age group. They will very much be the very last cab off the rank.'

Professor Gold says mRNA vaccinations and even the viral vector vaccine were possibly unsuitable for the under-fives as they were potentially more reactogenic.

The first children to be vaccinated are likely to be those 12 years and over who have co-morbid conditions such as chronic lung illness, cystic fibrosis, chronic heart disease, renal disease or an immunodeficiency.

'Real-world effectiveness' is important in comparing the various vaccines' efficacy, so data from countries that have increasing rates of vaccine coverage will be significant. Data from countries such as Israel, which is on track to vaccinate most of its community, will be informative,' Professor Gold says.

'People are very focused on the clinical trial vaccine efficacy data but there needs to be clarity about the difference between efficacy and effectiveness.

'Efficacy is what you get in a clinical trial and effectiveness is what you get when you roll out the vaccine into the general community. When you roll out the vaccine you are going to get other variables affecting the ability of the vaccine to provide protection.'

*Professor Mike Gold*

Regardless of the impact of the vaccine, Professor Gold is confident universal precautions are likely to be required for some time.

An article in *Paediatric Allergy and Immunology*[1] raises concerns about children with allergies who have symptoms, such as coughing and sneezing, similar to those of COVID-19.

'As we move forward, allergy symptoms may prevent patients from working, go to school, or access medical services that increasingly are allowing only asymptomatic individuals,' the authors wrote.

Children with allergies are unlikely to be vaccinated in the near future, if at all, which may cause them to be excluded from many activities, including travel if it requires a vaccine as a 'gate pass'.

'I've just had to rush off a letter for a patient because the GP is refusing to see a 15-year-old child with a headache without a COVID-19 test, but the child has symptoms of hay fever associated with the headache and likely to have a rhinosinusitis as the cause of headache. Hay fever symptoms are very common – they affect one in four children,' Professor Gold says.

[1]*A Cianferoni and M. Votto, COVID-19 and allergy: How to take care of allergic patients during a pandemic? November 2020, Pediatric Allergy and Immunology - Wiley Online Library*

# A place and support for all

**SAM PAULL**
STUDENT NEWS:
FLINDERS UNIVERSITY

As our second year of COVID-affected study is upon us at Flinders, I am entering my fourth and final year of study, a journey far removed from my past life as a hardware and SATCOM engineer. Last year brought with it numerous and varied challenges that were felt by all Australians, with medical students being no exception. As we move into 2021 with equal amounts of trepidation and optimism, it is important for us to reflect upon the lessons of the past year, so we prepare ourselves for the challenges ahead, and to take stock of the situation as it stands. Currently we are fortunate that the restrictions in place in South Australia allow students to attend both educational and social events in person. The pre-clinical student cohort can attend lectures and tutorials, with the coveted dissection program also resuming. However, pre-clinical students are unfortunately unable to conduct their usual clinical encounters on the wards, a unique part of the Flinders program that has been impacted by COVID.

Clinical students are excited to start their first placements for the year, with no restrictions to participation other than those that apply more generally to the hospitals such as QR check-in and social distancing measures. On the social events front we are cautiously optimistic that the normal gamut of O'week activities such as lunches, presentations, quiz nights and social drinks will go ahead. With a bit of luck, we will also be able to run our larger social and educational events as the year progresses. Social activities not only give students a chance to wind down but provide an opportunity for interaction between the usually separate clinical and pre-clinical cohorts.

Unfortunately, while things are going well for the local students, the situation is less positive for our international student cohort. Students who would normally be able to return home to their families over the Christmas holiday break have largely decided to remain in Australia, and it is looking increasingly unlikely that they will be able to return home at any point this year. This isolation from loved ones can cause an incredible emotional toll and the Flinders Medical Students' Society (FMSS) is working collaboratively with Flinders University to support these students. The incoming cohort of international students starting their first year of medicine will also have a disrupted experience, as it is unlikely that they will be able to attend any of their first year in person.

During the pandemic, many businesses and workplaces have found themselves needing to transition to a working from home environment, resulting in a revolution of sorts in workplace flexibility. A 'studying from home' medical degree is however not ideal and presents a unique challenge. The university is leveraging the lessons learned from the remote learning environment last year to deliver a pre-clinical medical program entirely online for the international students, but this is complicated by the fact that the program must be delivered simultaneously to the local cohort. FMSS recognises the importance of collegiality and unity within our student group and that fostering a sense of togetherness, when a proportion of the students is unable to attend in person, will be a challenge. We are hoping that by involving all students, local and international, in online events such as 'meet and greets' and quizzes, we will support all medical students and ensure that the remote students feel included.

> *'FMSS recognises the importance of collegiality and unity within our student group'*

The absence of international travel has also resulted in all final-year elective placements being replaced with local alternatives. Although this is disappointing for students who were keen to obtain medical experience abroad, it has also resulted in positive new relationships with South Australian private health networks that are taking up some of the load. It also has resulted in a much larger than usual group of students attending placements in Darwin and Alice Springs, strengthening our ties with these areas and providing a different perspective on healthcare.

For all its challenges, 2020 taught us not only to appreciate how good we have had it, but also how to be flexible and adaptable. Our second year of COVID-affected study will no doubt present us with new problems to solve, but I'm confident that, as we did last year, we will adapt and thrive on our journey toward graduation.

# The more things change ....

**PATRICK KENNEWELL**
STUDENT NEWS:
ADELAIDE UNIVERSITY

Just over 100 years ago, isolation tents were set up on the main campus of the University of Adelaide, on Frome Road where our old medical school stood. This was to combat the Spanish Flu, at a time when state borders were closed between South Australia and Victoria. Having experienced the whirlwind that was 2020 and the ongoing COVID-19 pandemic, I now walk across campus reflecting on what life must have been like as a medical student at that time, and whether we share the same experiences and challenges as those before us.

Last year proved to be a very different year for every medical student at Adelaide. Students across all year levels experienced changes to their university experience, whether changing teaching methods, removal from hospital-based placement, or a lack of social and extra-curricular opportunities.

One of the most significant changes was the move to entirely online teaching, with all lectures and tutorials being held via Zoom. This transition was met with mixed reviews, with some finding the new teaching mode less engaging and others enjoying the move to studying at home and turning up to their online class just after waking up, coffee on hand. The Adelaide Medical Students' Society (AMSS) is grateful to the clinicians who spent hours creating online resources and running lectures for us during this time.

For the first-year cohort the shift online began only weeks after starting medical school. They didn't receive the same opportunities to meet their peers and get to know older students before moving to online learning. An overarching goal for the AMSS this year is to rectify this: we aim to offer social events on and off campus for the commencing first and second years, to demonstrate the camaraderie we are renowned for.

When placements were cancelled last year, clinical students went back to lectures and book-based learning during their long hiatus from the wards. Students found ways to fill their time through studying the large number of resources we were given in lieu of placements, including spending time helping with the contact tracing for SA Health, temperature testing at workplaces across Adelaide, picking up research projects in areas of interest, or picking up new and old hobbies like baking or playing golf.

*Jubilee Oval, now part of the University of Adelaide's Frome Road near campus, accommodated hundreds of South Australians during the 1919 Spanish Flu pandemic.*

> ***'... we were all grateful for the new skills and the experience ...'***

My experience last year involved an exchange trip to Aarhus University in Denmark with eight other fifth-year students for our paediatric, obstetrics and gynaecology terms. We left Adelaide in January expecting a six-month exchange program and making the most of our time with weekend trips to Copenhagen, Skagen, Stockholm, London, Prague and Hamburg. Unfortunately, eight weeks into our placement we began to see families returning to Denmark from the Italian Alps falling ill with what turned out to be COVID. Shortly after Denmark went into a full lockdown, we were sent back to isolate and continue the year in Adelaide. Despite our shortened exchange program, we were all grateful for the new skills and the experience within a different healthcare system and culture to our own.

The AMSS was proud to work extensively with the medical school faculty in 2020 to facilitate the prompt return of students to placement and offer a great deal of assistance to international students who were stuck in their home countries and unable to return to Adelaide. We have ensured that these students are able to continue their studies online until they can join us in person. In 2021 we have a new cohort of first-year international students who will be studying entirely online until they are able to come to Australia, and this presents a new set of challenges for us to ensure they feel part of our community.

Restrictions around overseas placements have meant that sixth-year students have been looking for exciting experiences closer to home, with some students on placement with Medstar or the RFDS, and others securing placements all across Australia, with Darwin, Alice Springs and the Whitsundays being popular destinations.

We are looking forward to what this year holds and are optimistic about what we can achieve. We have opened the year by hosting a Clinical Students' Welcome Event at the Lion Arts' Factory on North Terrace and are eagerly awaiting the start of pre-clinical year, with plans for a big O'Week 'meet and greet' along with a modified Skullduggery and MedCamp to meet restriction requirements. Our committee hopes to do the long legacy of the AMSS proud.

We invite you all to keep in touch with us on our Facebook page or at our Instagram @youramss; otherwise feel free to send me an email at president@amss.org.au with any questions or suggestions for 2021.

*Photo courtesy of: Papers of Hübbe and Caw families 1859-1988, Series 63, Box 6, the University of Adelaide Rare Books and Manuscripts Blog*

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

# Trying this at home

General practitioners have a central role in a new program bringing hospital care to South Australian patients in their homes.

For the first time in South Australia, general practitioners will be able to refer public patients to Wellbeing SA's new home hospital service, My Home Hospital.

My Home Hospital is a Wellbeing SA service delivered by a joint venture between Calvary and Medibank following an open tender in 2020.

Executive Director of Integrated Care Systems at Wellbeing SA Jeanette Walters says while home services have existed to support patients following admission to a hospital, My Home Hospital will bring acute care into the home as a first choice for patients with certain conditions.

'Previously, it's been people in our hospital system who've then gone on to access home hospital programs under the governance of the acute hospitals – that's been the pathway,' Ms Walters says. 'With My Home Hospital, general practitioners now have the opportunity to make referrals directly, supporting people who they see on a regular basis who need hospital-level care, to receive treatment in their own home.'

The launch of My Home Hospital provides an integrated and person-centred addition to the health system, backed by a review of best practice hospital-in-the-home models in Australia and overseas as well as consultation with clinicians and consumers.

My Home Hospital involves a senior team including a medical director, medical officers and nurses to provide 24/7 acute care. Ms Walters says it partners with a single provider to offer everything from diagnostic tests such as x-rays, blood tests and medication to cleaning services.

'The community has been telling us they want more access to home hospital care for a long time, and we've been working out how to do it. Where there is a safe alternative available, they don't want to come to hospital – they want to be able to stay in their home.

'There are a lot of arrangements where people would prefer to be at home, but this is particularly true when they have family or loved ones they are either caring for or who are caring for them ,' Ms Walters says.

Victorian models suggest the service will be valuable for families, as well as for those with complex needs such as people living with disability or in residential aged care.

'The ability to fit in with a patient's other health and care providers will make for a more accessible and joined up service, as well as a better patient experience for a lot of people,' Ms Walters says. 'We're keen to keep learning as we go, to work out how we can continue to make this a service that adds value to the health system.'

The new model is designed to build partnerships with referring GPs.

'It's called integrated care for a reason,' Ms Walters explains. 'It's the mindset that we are partners in care, if there are things that need clarifying during a patient's admission or as a patient approaches discharge, the team will be in contact with the GP.

'Our providers have made a big call, saying discharge summaries will be provided within 24 hours after discharge. It has been very clear that this has been an ongoing frustration for general practice – that someone comes back into their care and they don't always have the information they need to support that care.

'We've been listening, and we've been trying to use the opportunity to ensure that we are really keeping the patient at the centre of care and working together as a team around them.'

Under the new arrangements, GPs or other clinicians will be able to complete a referral form (which will soon be integrated with practice software) or call to ascertain a patient's eligibility. My Home Hospital clinicians will contact the patient and their referring doctor to ensure that home care is appropriate.

*Ms Jeanette Walters*

Nurses or doctors will visit patients in their home at least once a day and can also provide support via video call. Remote monitoring technology will track clinical observations in real time, and patients will have a call button for emergencies. The team will ensure that patients who have ongoing care needs are discharged back to their usual care provider or referred to new care options.

'It is a medical service and it is supposed to replicate a hospital. If a person lives at home and is feeling particularly unwell, we can talk to them about other support such as meals or showering – things that we heard would be really valuable but have not previously been available,' Ms Walters says.

Treating patients at home helps to lower the risk of infections and falls, and can help to direct resources into patient care, Ms Walters says.

The service is limited to conditions conducive to home care, with an initial focus on cellulitis, respiratory infections or inflammations, kidney and urinary tract infections, chronic obstructive pulmonary disease and venous thrombosis. In July 2021, this will expand to include cystic fibrosis, lymphoma and non-acute leukaemia, heart failure, chest pain, non-malignant breast disorders, pulmonary embolism and aftercare of musculoskeletal implants and osteomyelitis.

The team is open to conversation with clinicians and at any time, referrers are encouraged to call the team to discuss patient eligibility.

The service is currently available in metropolitan Adelaide but will extend to the Barossa, Adelaide Hills and the Fleurieu Peninsula from July.
Referral forms are available at myhomehospital.sa.gov.au or referrers can speak to a doctor or care coordinator on 1800 111 644.

# Magic and wonder

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

*Dr Troye Wallett is a GP who likes to reflect on the magic of science and marvel at its opportunites. He would love to hear from you. Email him at* troye@troyewallett.com

It is a time of magic. Our lives are full of wonders that have become mundane by the speed of change. But there is a scary side of advanced tech, and some people are wary and long for the pre-digital days. For now, though, let's leave the fear of change behind us and revel in its wonder.

Perhaps, like me, you ponder: 'How is it possible to video chat with my sister across the world with no lag?' The answer, 'Magic!'. Understanding all of the devices, breakthroughs and innovations in so many realms of human endeavour has become impossible, and it is pleasing and fun – even useful – to define them as magic, drawing on Arthur C Clarke.

## 'THE MAGIC IS, THERE IS NO MAGIC!' – SETH GODIN

Characterising technology and innovation as 'magic' is not to discourage exploration and the pursuit of understanding. Nor is it denying science and physics. Instead, it cultivates a sense of fun and a mindset of wonder and inspiration that helps create an environment in which ideas flourish.

It is almost trite to write about the magic of smartphones, communication technology and computers. Yet there can be no denying that there is magic in development in Adelaide, with potentially phenomenal and awe-inspiring outcomes.

## IT IS ALL SCIENCE FICTION

This is a time in which science fiction has become fact.

For the first time, it is cheap enough for states and companies to explore opportunities in space. In Lot Fourteen – the space that was the old Royal Adelaide Hospital – there are multiple companies with space as their focus. There's talk about building spacecraft that will fly South Australian hardware to the moon. Satellites are being built in Lot Fourteen, with our state the first in the world to develop and launch a satellite into orbit. SASAT 1 is a communications satellite designed to gather data for emergency services, farming and state services.

In the next two years, people will return to the moon, and in the next 10 years, someone will set foot on Mars.

It is the start of the Space Age.

## THE AGE OF INTELLIGENCE

In the same precinct is the University of Adelaide's Institute for Machine Learning. Machine learning, also called artificial intelligence (AI), is the next revolution.

The Industrial Revolution introduced factories and mass-produced mechanical machines. Cars are commonplace because of the Industrial Revolution.

The Electronic Revolution added microchips and computing to the machines of the Industrial Revolution. Our cars have cruise control and ABS braking because of it.

The Machine Learning Revolution adds AI to computers and will make the world unrecognisable in the next few years. It is the reason autonomous

vehicles are predicted this year, and kids who are younger than 10 years old may never have to learn to drive.

## HEALTH TECH

The health space is not immune to this kind of 'magic'. To many people, the medications we use, the surgical procedures, and the biotech used every day are, or at least appear to be, magic.

Medicine and healthcare are changing as fast as the technology in our pockets. Life Whisperer, a company that's also based in Lot Fourteen, uses AI to select those embryos that have the highest possibility of a viable pregnancy. The algorithms have a 25 per cent better success rate than currently used methods.

Professor David Sinclair is a University of NSW PhD graduate and director of the Harvard Center for the Biology of Aging. He believes that ageing is a disease and is working on a 'cure'. In his book *Lifespan*, he outlines his argument and describes the breakthroughs he and his team have discovered. He predicts that the babies of today may live to be a healthy 120 years old.

## WONDROUS

In the 1970s, Alvin Toffler wrote the book *Future Shock* in which he defines the term 'future shock' as the stress and disorientation people feel in the face of rapid change. It is the awe and fear that is felt when reading about the space race, AI and the idea that ageing may be 'cured'. When technology threatens how we work or live, this fear becomes more pronounced. But change is inevitable, so it is up to us to reframe how we approach it.

When a reporter asks an Olympic athlete if they feel nervous before a race, they reply, 'No, I felt excited!'. Excitement and nervousness feel the same: heightened awareness, fluttering in the chest and that sense of pending action. Elite performers learn to think of that emotion as a positive experience.

The 'future shock' emotions we may feel can be reframed as awe or wonder if we choose. Thinking of incomprehensible technology as magic helps with that reframe. It is the Age of Wonder, and we can choose to revel in it or be frightened of it. I know which one I'll be choosing.

***'... It is the Age of Wonder, and we can choose to revel in it or be frightened of it ...'***

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# welcome
## Dr Jake Jagiello and Dr Claire Bolton

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**Dr Jagiello's specialties include:**

Hips, knees, revision surgery, trauma, bone and soft tissue sarcoma together with metastatic bone cancer.

**Dr Bolton's specialities include:**

Hips and knees, including ACL reconstruction, patella instability, hip and knee replacements and general lower limb trauma of the hip, knee and ankle.

At sportsmed, our world-class team of orthopaedic surgeons specialise in the assessment, treatment and recovery of orthopaedic, sporting, musculoskeletal and arthritic injuries and conditions, including bone and joint care.

Our sub-specialists are highly trained in a range of techniques from minimally invasive, arthroscopic procedures to joint replacements and reconstructions for surgery of the hip, knee, foot, ankle, shoulder, elbow, wrist and hand. Feel confident referring your patients to sportsmed, knowing we strive to provide the best patient care and experience.

For all appointments and enquiries with Dr Jagiello and Dr Bolton, contact **08 8362 7788** or email **ortho@sportsmed.com.au**.
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# ‘Tactful, firm and a willing mentor’

## Dr Desmond Hoffmann OAM

1936 – 2020

*Dr Desmond Hoffmann*

Desmond Hoffmann was born in Adelaide, the youngest of three siblings. He married Margaret Spehr, who was a nurse at the Adelaide Children’s Hospital, in 1961.

The young Des Hoffmann graduated from the Adelaide Technical High School and was awarded a Commonwealth Scholarship to study dentistry but changed to a medical degree after his first year at university. Upon completion of his medical degree in 1963 he became a resident medical officer, and then in 1964 a registrar under consultant surgeon Mervyn Smith.

Des was interested in academic as well as surgical studies and he became a research fellow in the University of Adelaide’s surgical department under Professor R. P. Jepson. Several papers were jointly published relating to the influence of the sympathetic nervous system on peripheral blood flow.

In 1967, and now including three young children, the family moved to London, living on a registrar’s salary and long hours on duty at St George’s Hospital. Dr Hoffmann received an appointment as senior registrar at the Professorial Unit at St George’s Hospital London under Mr O.V. Lloyd Davies, a leading gastroenterology practitioner. Des was awarded a Commonwealth Medical Scholarship and he became a Senior Registrar with time to continue academic studies.

A reference from Professor B.N. Brooke, St George’s Hospital is of significance. ‘(Des) is a mature person who has assimilated much knowledge and developed very sound clinical judgement. Moreover, he is an excellent surgeon who has acquired considerable technical experience,’ Professor Brooke wrote.

After a year in London and with the benefit of the Commonwealth Medical Scholarship, Des took up a position at the General Infirmary Leeds, under head of surgery Professor J.C. Goligher. A reference from Professor Goligher, written as Des prepared to move back to Adelaide, is another insight to his competence. ‘It has quickly become apparent that the eloquent praises that they have bestowed on (Dr Hoffmann) are justified, for he has proved to be easily one of the brightest, most pleasant and promising young men I have ever had in my department,’ Professor Goligher wrote.

Des returned to Adelaide and began at the Royal Adelaide Hospital. He was a consultant/senior visiting surgeon from 1971 to 1999, and Emeritus Surgeon from 1999. He established the colorectal surgical unit at the Royal Adelaide Hospital, and introduced stomal therapy at the hospital and in South Australia at a time when many stomal treatments were unknown or rarely practised.

In 1972 he commenced private practice but continued to be involved in the development of and innovations in colorectal surgery, with many commitments to national and international affiliations. In 1988, he was invited to become a foundation member of what is now the Colorectal Surgical Society of Australia and New Zealand, and he was President from 1993 to 1996. His leadership roles with national and international associations included the Executive of the World Council of Colo-proctology and South Australia’s Medical Defence Association.

During his decades of service to South Australian colorectal patients, Des became known for his dedication and commitment – and particularly for his willingness to mentor young students and doctors, and to guide them on their paths to colorectal surgery or other specialties.

In 1978, Des attended an international gastroenterological meeting in Madrid at which Professor Goligher presented a paper demonstrating the use of a Russian stapler instrument to staple together sections of bowel. At that time, trade between Russia and the Western World was forbidden. It is claimed Des bought the gun for $1,500 cash in a dark alley in London with the exchange of two bags, and that the gun was later given to Bob Britten-Jones for transfer to Australia. It has never been clear how the gun passed customs in Australia. This instrument provided some controversy in the surgical fraternity but now rests in the Calvary Hospital’s museum at North Adelaide.

Des was a very competitive sportsman. He played for Norwood Football Club between 1955 and 1958. He played in Norwood’s losing side in the 1957 South Australian National Football League (SANFL) grand final against Port Adelaide, before a crowd of 58,000 at Adelaide Oval. His last SANFL game was the 1958 first semi-final.

Tennis was also an important part of his life. Des played with a very competent group and this continued until he was 80 years of age. Fishing and boating at his holiday home at Mission Beach in Queensland provided great holidays. Des had an intense interest in sporting cars and this included annual holidays driving around Europe, even in his later years.

In 2018 he was awarded an OAM ‘for services to medicine and to colorectal surgery’.

It was evident at his funeral service that Des was loved by his family and adored by his grandchildren. Des was tactful but firm; always punctual and not given to wasting time.

Des died suddenly and unexpectedly at Mission Beach. He is survived by his wife Margaret; children Mark, Anna, Rebecca and Ben; and eight grandchildren.

*Dr David King AM*

## MARCH COUNCIL MEETING

The next meeting of the AMA(SA) Council will be held on Thursday, 4 March 2021.

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

## AMA(SA) GALA DINNER

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

The black-tie event will be staged at the Adelaide Town Hall. COVID-19 restrictions have delayed the finalising of some details, but we're planning for a wonderful night. Organise a table for what promises to be a wonderful evening.

The Gala Dinner will include the handover of the presidency and vice-presidency. AMA(SA) annual awards will also be presented. If you wish to nominate a colleague for an award, please note that nominations close on 25 February 2021.

There are two awards: the 2021 AMA(SA) Award for outstanding contribution to medicine by an AMA member, and the 2021 AMA(SA) Medical Educator Award. Nomination forms may be obtained by emailing Mrs Claudia Baccanello at claudia@amasa.org.au.

For more information and updates about the Gala Dinner dinner, please look for notices in The Voice e-newsletter and on our website.

## AMA(SA) ANNUAL GENERAL MEETING

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

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

## NOMINATIONS FOR AMA(SA) COUNCIL

AMA(SA) members are invited to consider nominating for AMA(SA) Council. The Council has vacancies as specialty group representatives and public hospital doctors; please note that you must be nominated by others in your specialty group.

If you are interested in nominating, please contact Claudia Baccanello on 8361 0109 or at claudia@amasa.org.au for a nomination form. For other queries about joining Council, please contact AMA(SA) CEO Dr Samantha Mead at CEO@amasa.org.au.

Nominations close at 5 pm on 24 March 2021.

## DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

If your contact details, place of employment or membership category has changed recently, please let us know so we can update your details.

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

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



# PROFESSIONAL VACANCY

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# PRACTICE NOTICES

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

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

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

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

**NEUROSURGEON DR EMA KNIGHT** has commenced private practice, consulting from Suite 2, Memorial Medical Centre, 1 Kermode Street, North Adelaide, 5006.

Dr Knight welcomes adult neurosurgical referrals. For enquiries or to discuss a referral please contact 7127 2298.

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**Adelaide Town Hall**

## Saturday, 22 May 2021

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**Non-members welcome**

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**Contact membership@amasa.org.au**