medicSA
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Higher office

The new AMA(SA) leadership team

AMA SOUTH AUSTRALIA

COMMITMENT TO CLIMATE ACTION • 2020 STUDENT MEDAL WINNERS
NEW VACCINE EFFICACY EVIDENCE • END OF LIFE ADVOCACY • DISPATCHES

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Contents

It was no surprise to anyone that outgoing President Dr Chris Moy wore a Crows scarf and brought a friend, Yoda, to assist in his farewell speech as President at the AMA(SA) Gala Dinner on 22 May. What was unexpected was the presence of a rainbow-hued feather duster, which CEO Dr Samantha Mead presented to Dr Moy in response to his recent comments that he'd soon be as useful and valued as a feather duster. Judging from the crowd's response, there'll be no chance for him to hide in the cleaning cupboard just yet.
For more Gala Dinner news and photos, see pages 16-19.

President's report

Dr Michelle Atchison

As I write this, I have been in the AMA(SA) 'hot seat' for exactly four weeks. As you know, I was elected as President after two years as Vice President of AMA(SA), and I have many years' experience on Federal Council. I knew what to expect. But if there is anything this month has taught me, it is that there is an enormous difference between watching and doing – even from the vantage points I was fortunate to occupy.

For four years, I witnessed Associate Professor William Tam and (now) Immediate Past President Dr Chris Moy leading our members, and using their AMA(SA) platform to help members and colleagues secure better care and services for people and communities across the state. They were, and are, fantastic role models and mentors for a new President who wants to do the job well.

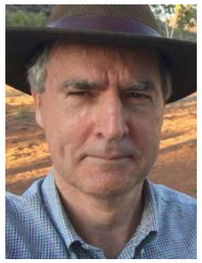
Chris could not have possibly foreseen that his presidency would be dominated by a once-in-a-lifetime global pandemic. Similarly, with COVID-19 still the main topic in government, media and watercooler gatherings across Australia, I cannot ease into the position as my predecessors have done. South Australia has a long way to go and much to do before we can return to whatever 'the new normal' looks like, and AMA(SA) can and must contribute significantly to the decisions that get us there as soon as possible.

It is because of our calm, objective, patient-focused and evidence-informed approach throughout the pandemic and in so many areas of health care that the AMA is 'in the room' for policy-making and other top-level discussions. I will certainly be continuing that approach in the regular meetings we have with Health and Wellbeing Minister Stephen Wade and his colleagues; earlier this month, we had the first of these regular meetings since I became President, and – alongside new Vice President Dr John Williams – discussed the delayed vaccine rollout in rural areas, especially Kangaroo Island; public health messaging about where to receive a vaccination and to overcome vaccine hesitancy; the vaccination of aged-care staff; and starting to develop a medium-term plan for the health system coping with an outbreak in South Australia. And planning for the Women's and Children's Hospital, and the ongoing issue of access to world-class care in our rural and remote communities. Not a bad agenda for a first meeting!

The pandemic has obviously been a circuit-breaker in how we think, and what we think about, in both our personal and professional lives. To me, especially in this position, it has reinforced that the delivery of health care is and always must be a priority – for us as doctors, but also as people: as parents, children, carers, siblings, colleagues and friends. Even before the pandemic, was there a day that we didn't talk or think about someone's health and wellbeing? A doctor's appointment, a parent's medication, a child's vaccinations, a friend's cancer diagnosis? Health, and how we treat and care for it, is an everyday 'event'; as doctors, and AMA members, we really are privileged to be in a position to do something about it. I'm extremely thankful to be assuming the AMA(SA) presidency at a time when the Council is engaged and willing to give the time and energy to help 'do something'. I appreciate our junior doctor Council members and medical school representatives providing their perspective on the issues we've debated for years while illuminating the importance of emerging issues such as the impact of the health industry on the planet and health as a global climate emergency, and their willingness to stand up for themselves and each other and fight for safe working conditions and workplaces.

I have had to reflect on this important position, in what is a strange, challenging and extremely important time to be President of AMA(SA). Many people have asked what the new job is like. I have decided that the best description is that it is like juggling six eggs in the air – and not hardboiled ones! With all AMA(SA) members support behind me, let's hope the eggs stay in the air.

As I write this, AMA President Dr Omar Khorshid is releasing a 'Vision for Australia's Health', which aims to make our country the healthiest in the world. I look forward to working with this state's doctors, medical colleagues and health decision-makers to determine how best to achieve the ultimate goal of Omar's vision – safe, high-quality, patient-centred care for all.



Medical editor's letter

Dr Roger Sexton

medicSA has been part of my professional life for a long time, and I am delighted to be contributing to it as the new medical editor.

This magazine will remain an important source of information for the profession and the broader community about the impact of the work and lives of doctors and students. Each edition will explore the sources of this impact and how, where and why doctors and students are making a difference.

medicSA is local and relevant to all doctors. With each edition, we will offer a forum for information and articles that highlight the activities and impact of the wider profession and the efforts and leadership of AMA(SA). It will also aim to broaden your understanding of professional matters of interest, new trends and discoveries, and alert you to special events.

I invite all readers to consider contributions to *medicSA*, to broaden the readership and content of the magazine and provide a forum for the opinions of our present and emerging leaders.

Change is the prerogative of a new editor and this June edition introduces the first of a new series of interesting medico-legal articles. We also feature the recent celebration of senior rural doctors and their ongoing contribution to rural communities, and how crazy combinations of socks can be good for your mental health.

Future editions will also include articles on the wellbeing of the profession and sustainable doctors, and our many and varied creative pursuits.

medicSA is your professional publication that will continue to inform, entertain, celebrate and inspire you and enrich your life with articles of interest.

I am most fortunate to be working with the dedicated team of AMA(SA) staff who believe in us, the medical profession and the power of communication, information and good journalism.

I also warmly thank my predecessor, Dr Phil Harding, for his creativity and guidance of *medicSA* towards national recognition over the last 20 years. As our article on page 9 demonstrates, his legacy has extended to his other roles as a father and husband, a respected colleague, a mentor and teacher, and an outstanding endocrinologist who truly cared for his patients.

Finally, congratulations to the 11 South Australian doctors - including AMA(SA) members Dr Patrick Coates AO, Dr Phillip Aylward AM, Dr Michael Schulz OAM, and Dr Richard Willing PM OAM - who were among the recipients of Queen's Birthday Honours, and whose efforts will be recognised in the August issue.

AMA(SA) Council – back row (from left): Dr Andrew Russell, Mr Emerson Krstic, Dr Clair Pridmore, Dr Penny Need, Dr Ekta Paw, Dr Simon Macklin, Dr Hannah Szewczyk, Dr Shriram Nath, Dr Rajaram Ramadoss, Dr Karen Koh, Dr Cathrin Parsch, Professor Ted Mah

Front row (from left): Associate Professor William Tam, Dr Bridget Sawyer, Immediate Past President Dr Chris Moy, President Dr Michelle Atchison, Vice President Dr John Williams, Chair Dr Peter Subramaniam, Dr Danny Byrne, Professor Tarun Bastiampillai

Absent: Dr Brian Peat, Dr Simon Lockwood, Ms Shehani Gunasekera, Dr Nimit Singhal, Dr Patrick Quinn, Dr Laureen Lawlor-Smith

Leading by example

Decisions are made by those who turn up – and the new AMA(SA) Council is ready to consider, debate and act as required.

The Annual General Meeting brings with it a changing of the guard, including members who have offered their expertise and time to join AMA(SA) Council.

As Dr Michelle Atchison said:

'As incoming President, it is very pleasing to have a Council that is gender and culturally diverse, represents so many specialties, and includes metropolitan and rural doctors, senior and junior doctors, and medical students.

'If the first meeting of this new Council (on 3 June) is any indication, we can look forward to lively, engaged debate on matters of critical importance to our members, our profession, and the standard of health services in this state. I hope we will be contacted about issues of concern, so Council is in the best position to advocate on behalf of members and our patients.'

Dr Atchison and ongoing members of Council welcomed 'the recruits' at the June meeting.

Dr Cathrin Parsch (emergency medicine representative) is an emergency physician working as a staff specialist at the Lyell McEwin Hospital and SAAS MedSTAR. She is also a visiting consultant with the Central Australian Medical Retrieval and Coordination Centre in the Northern Territory.

Dr Brian Peat (obstetrics and gynaecology) has worked in a variety of positions (including as a trainee psychiatric nurse, construction and even as a truck driver) before studying medicine at the University of Sydney and completing his specialist training at King George V Hospital under the mentorship of Dr Andrew Child. He moved to Adelaide in 2001 and continues to be a champion of the local lifestyle.

Dr Karen Koh (dermatology) graduated from the University of Adelaide School of Medicine in 1995 and worked in general medicine, emergency medicine and sexual health at the RAH before specialising in dermatology. She has also been involved in skin research projects at Flinders University.

Dr Ekta Paw is Chair of the AMA(SA) Doctors in Training Committee. She has a strong interest in surgery and public health. She is currently studying dentistry, aiming to train in oral and maxillofacial surgery and has a Master's Degree in public health from the Johns Hopkins Bloomberg School of Public Health. She is now midway through a PhD at James Cook University and has been engaged with the AMA since internship.

Dr Laureen Lawlor-Smith is a general practitioner at McLaren Vale. Dr Lawlor-Smith will bring her experience in general practice, practice management and health governance in the Fleurieu region to the casual vacancy position she holds until the 2022 AGM.

Mr Emerson Krstic is the new student representative from Flinders University and has already contributed to Council debate. He has noted during discussion of rural campuses that any new programs must be established and continue to be managed with the appropriate academic expertise and other support so that rural students are not disadvantaged.

Ms Shehani Gunasekera is the student representative for the University of Adelaide. Hailing from Sydney, Ms Gunasekera has had many engaging rotations in her final year, including obstetrics and gynaecology with paediatric gynaecology. She has a keen interest in pursuing paediatric/adult physician training or general practice in South Australia or New South Wales. As well as working with the AMSS, she is a member of the Adelaide University Paediatrics Society.

VALE

For fellowship

Dr Philip Harding AM BMedSc, MBBS, FRACP

1941 – 2021

Dr Philip Harding

'*Carpe diem*' (seize the day) was a leitmotif of the life of former medicSA editor, AMA(SA) president and endocrinologist Dr Philip Harding, who died on 25 May.

Dr Harding remained enthusiastically engaged with the South Australian medical community into his last weeks. He had an inquiring mind and a rare ability to see both sides of an argument – demonstrated by his approach to the age-old debate between road users. False dichotomies such as that between cyclists and motorists are a poor basis for policy, he explained as chair of the State Cycling Council to The Advertiser some years ago.

A keen cyclist, Dr Harding was also enthusiastic about motoring, taking regular forays into the South Australian countryside with *medic*SA partner-in-crime, Dr Robert Menz, to test the latest and greatest vehicles in the Adelaide market for readers.

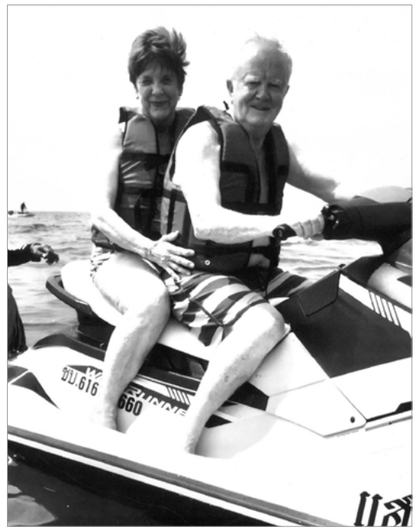
This ability to see the world through another's eyes, and describe it with a scholarly turn of phrase, also characterised his work as head of the Endocrinology Unit at the Royal Adelaide Hospital (RAH) and at AMA(SA), where he was a key player for more than 30 years.

As he noted in the RAH's Foundation Day William Wyatt Oration in 2002:

Whenever we are confronted with a new, foreign or unfamiliar group of fellow human beings, the first step in developing understanding is to find some common ground. Those of us who belong to international medical associations take great joy in the bond of fellowship which exists between doctors and which transcends ethnic and cultural boundaries.

And that is how Dr Harding came to advocate for Villawood detainee Dr Aamer Sultan, an Iraqi doctor seeking asylum in Australia, as enthusiastically as for improvements to rural medicine or public awareness of diabetes.

Those who knew him best agree that Dr Harding was not an easy person to categorise. As a venerated physician, member of the Australian Health Ethics Committee, and ex-serviceman with the Royal Australian Air Force, he presented as a pillar of the Adelaide medical establishment.



Dr Harding and Mrs Margie Harding

Yet Dr Harding's pathway to the Adelaide medical community was not typical of the time. Born in 1941 in Bedfordshire, England, Dr Harding lived in London with his mother until 1951, after his father, a naval officer, died as the HMS Penelope was sunk in 1944.

His mother remarried and the family emigrated to Tasmania in 1951, where Dr Harding was a boarder at Virgil's College – an experience he found challenging as a 10-year-old immigrant. He moved to Hobart High School as a day boy before moving to Adelaide – initially to Salisbury North where his parents were teachers, and later to Adelaide Boys High School.

... continued on page 11

Dr Harding with then-AMA(SA) President Dr Chris Moy

Dr Harding with fellow Past Presidents Assoc Prof William Tam and Dr Janice Fletcher at the gathering for Dr Moy's election as Federal AMA Vice President in August 2020

... continued from page 9

Clever at making things with his hands, a great singer and a talented pianist, Dr Harding may have taken a different path had he not been captivated at the age of 15 by the epic struggles of medicine as described by author Frank G. Slaughter in *East Side General*. After securing a number of scholarships, he went on to study medicine at the University of Adelaide from 1958, joining the RAAF Undergraduate Scheme.

He met his future wife Rosemary McGrady, a member of the prominent Northern Territory pastoralist family, during a vacation in Alice Springs in 1960 and they married in 1964. Their union continued for more than 50 years, and included four children and eight grandchildren.

The pair moved to Malaysia with the RAAF before a series of 'medical misadventures' beset their young family and caused Dr Harding to return to South Australia. He completed his physician studies at the RAH in 1970 and the family de-camped to London and Pittsburgh after Dr Harding won a Commonwealth Medical Fellowship for specialty training in endocrinology.

They returned when Dr Harding was appointed as a consultant endocrinologist at the RAH, becoming Head of Department and chairman of medical staff, developing a highly regarded unit with an outstanding record of external grants and engaging teaching. During this period, he also took great delight in performing in the RAH revues, including a highly acclaimed performance (dressed as a patient, complete with catheter bag) of *The Impossible Stream*.

He later contributed to the RAH diabetes centre, eventually becoming an emeritus consultant. He moved to private practice in 1997, becoming an external consultant to the Therapeutic Goods Administration on regulation of new medicines. He also retained an enduring relationship with the RAAF as a civilian consultant for clinical problems and on medical reclassification issues in the services.

Like Winston Churchill, whose prodigious body of work was based on an ability to survive on just four hours of sleep a night, Dr Harding preferred to use the wee hours of the morning to get things done. And also like Mr Churchill, he was prone to catching up on the zzzs in odd downtimes – including at the dinner table – which, he protested, was no reflection on the conversation prevailing at the time.

Ever busy – working, making things from wood, playing music, reading, playing golf (moderately he claimed), and advocating for the medical profession – he remained deeply embedded in the medical community throughout his professional life. A keen social organiser and traveller, Dr Harding rallied the troops for a regular medical fraternity ski trip, combined with professional development and established the AMA(SA) golf day.

As president of the AMA(SA) between 1990 and 1992, Dr Harding was particularly keen to expand membership and to campaign for improved health services in rural areas – and as medical editor of *medicSA*, he continued to work to bring the profession together.

Dr Harding lost his wife, Rosemary, to her third bout of cancer in 2017 but remarried in 2018 after a four-month romance with Margie, a former Director of Nursing at the Memorial Hospital, whom he met at the closing day of the old RAH.

Both having recently lost a loved partner to cancer, the pair bonded over tea, conversation and a cheeky sense of humour. They travelled extensively until COVID clipped their wings and they entertained a lively passing parade of friends and colleagues - even during the last few weeks in hospital.

Dr Harding is remembered as a thoughtful, lively, caring, clever person and a champion of the medical profession, of which he was proud to be a member.

Dr Harding and Mrs Harding at their Kent Town home

Climate code black

South Australia's junior doctors are demanding change in response to the growing evidence of climate change impacts on health, writes AMA(SA) Doctors in Training Committee Chair Dr Ekta Paw.

AMA(SA) Doctors in Training Committee Chair Dr Ekta Paw

When I studied my Master of Public Health in 2019, I expected to be discussing disease treatment and health delivery. Instead, there was a theme I found repeated in every class: climate change. It seemed to have an impact on everything we discussed: how we live, the development of industry, how economies grow, the type of disease we treat, the way we deliver healthcare. Many doctors in training now seem to notice the same theme. After numerous conversations with colleagues, I felt it was important to ask AMA(SA) Council to clearly articulate an advocacy plan.

Junior doctors frequently reflect upon our responsibility as professionals to advocate for patient wellbeing outside the typical clinical setting – particularly on an issue such as climate change, which does have clear health impacts. The AMA(SA) Doctors in Training Committee presented some of the most recent evidence published in this area before proposing a motion for AMA(SA) Council to vote on at its June meeting. We wanted to establish an ongoing and coordinated effort in response to the growing evidence that climate change is a global health issue. This evidence includes statistics from the *CSIRO 2020 State of the Climate* Report:

- Australia's climate has warmed on average by 1.44 ± 0.24 °C since national records began in 1910, leading to an increase in the frequency of extreme heat events
- every year is now warmer than the upper limit of the range it would have been in a world without human influence, known as climate change 'emergence'
- there has been an increase in extreme fire weather, and in the length of the fire season, across large parts of Australia since the 1950s, especially in southern Australia.

The health impacts of climate change are wide and varied, as discussed in the 2018 *MJA–Lancet* 'Countdown on health and climate change: Australian policy inaction threatens lives':

- increases in temperature and weather-related disasters associated likely with increased mortality (burns, suffocation, inhalational injury from bushfires)
- increased vectorial capacity of infectious diseases (focus on A. *aegypti* in dengue)
- increased food insecurity, threatening malnutrition
- Mental health impacts.

Clearly, climate change is not simply an environmental issue: its impact on the health and wellbeing of people in our society is undeniable. The UK's National Health Service (NHS) has recognised this, and created a Sustainable Development Unit aiming for a 'Net Zero' National Health Service. By regularly measuring healthcare's carbon footprint and implementing guidance on energy use, procurement and waste, the NHS achieved an estimated 62 per cent reduction in carbon emissions in 2020.

In Australia there are few health system-wide, formally coordinated, efforts to achieve sustainability. One example is the Princess Alexandra Hospital in Brisbane:

- recycling of the 17,500m^2 of aluminium cladding product removed from the hospital's exterior
- the introduction of sugar-cane kidney dishes, replacing more than 680,000 single-use plastic consumables each year
- combined recycling – 637,481 kg in 2018-19, 524,995 kg in 2019-20 (2,281,926 kg recycled since 2017).

South Australia has established the South Australian Climate Change Strategy (SACCS), which includes plans to make the new Women's and Children's Hospital completely electric-powered, rather than relying on gas.

The AMA officially recognised climate change as a global health emergency in September 2019. Other medical organisations have also implemented actions to promote sustainability, including the Australian and New Zealand College of Anaesthetists' (ANZCA) sustainable waste management initiatives, energy consumption changes and carbon offsetting of travel activities; and the Royal Australasian College of Physicians' (RACP) pre-budget submissions to government calling for the divestment of funds from fossil fuel companies and its support for 'Doctors for Climate Action'.

Currently, AMA Federal and Doctors for the Environment Australia (DEA) have released joint statements that pledge for emission reduction of 80 per cent by 2030, and demands a National Sustainability Unit for Healthcare to procure medical equipment, pharmaceuticals and goods with low-carbon footprints; reduce travel emissions through telemedicine and electric vehicle fleets; and prioritise prevention, primary care and sustainable models of care.

An AMA(SA) working group can provide a consistent and structured approach. Within AMA(SA), we recommend implementing a sustainability policy, including carbon-offset flying, reducing flying where possible and transparency in investments with the aim of divesting from fossil fuels. We also support a state sustainable development unit to reduce carbon emissions in all aspects of the healthcare sector including public hospitals, private hospitals and general practices. The following motion was adopted unanimously by AMA(SA) Council on 3 June:

The AMA South Australia Doctors in Training Committee calls for the AMA South Australia Council to adopt an ongoing process dedicated to climate advocacy and to establish a working group of diverse AMA South Australia members to advocate for change within:
a) AMA South Australia
b) the healthcare sector, including the establishment of a state sustainable development unit
c) public policy.

Thanks to AMA(SA)DiT Committee colleague Dr Georgia Smithson-Tomas for her assistance in drafting this motion.

GPs' counsel essential to rollout

Australia's doctors should continue to use the trust their patients have in their advice to encourage them to be vaccinated against COVID-19, says AMA Vice President and general practitioner Dr Chris Moy.

Advertising at the Brittania Roundabout promotes South Australia's vaccination rates as at 20 June 2021

Dr Moy says uncertainty in the community about the risk of vaccination against COVID-19 has increased markedly since the announcement on 17 June that the recommended minimum age for receiving AstraZeneca in Australia be lifted to 60.

The Australian Technical Advisory Group on Immunisation (ATAGI) changed its guidance and increased the age for the AstraZeneca vaccine to 60 years and over based on a slight uptick of the extremely rare thrombosis with thrombocytopenia syndrome picked up in the 50-59 years age group in Australia, and remaining consistent in recalibrating the advice based on risk benefit in the as-yet low COVID environment currently existing in Australia.

Dr Moy says the change came as more Australians, and particularly those in the 50s and 60s age brackets, were overcoming hesitancy – especially in the light of virus outbreaks in Victoria and Sydney from mid-June.

He says the announcement has led to 'confusion' among Australians in the relevant age groups, and led to many people contacting their GPs about what to do. Many of those seeking advice are those aged between 50 and 60 who have received their first AstraZeneca, and who want to know if they should receive the second.

Dr Moy says the impact on general practitioners (GPs) and their practice staff has been 'immense'. But he says the change has reinforced the role of GPs in supporting patients throughout the pandemic – both in persuading them to be vaccinated, and in counselling them about balancing risks and benefits of the various vaccines and contracting and spreading the virus.

'Throughout the 18 months of the pandemic, the AMA has been careful to present a calm, balanced and independent perspective in our public discussion of and commentary on news, evidence, and advice,' he says.

'While advocating firmly for doctors, patients and the long-term future of our health system in behind-the-scenes negotiations with decision-makers at national and state levels, we've ensured public commentary has urged people to follow health advice, comply with state and regional quarantine restrictions, and, most recently, get vaccinated as quickly as possible.

'As doctors, our advice can make the difference in persuading patients to be vaccinated with the appropriate vaccine for their age group and health conditions. We can help them understand that it is vital for Australia's progress towards opening our borders to the world and that every person vaccinated is not only one person protected, but also one step closer to a normalisation of our world.

'The willingness of Australians to comply with evidence-based guidance and restrictions has been absolutely vital in this country achieving the status we are now enjoying,' Dr Moy says. 'But as pressure increases for borders to open – for both personal and economic reasons – so does the need for individual and collective immunity increase. As doctors, we have unique relationships with our patients, and we can capitalise on these relationships to answer questions and allay fears.

'In the coming months, discussions about vaccine passports or certificates will become more common, for leaving Australia for particular countries, for booking flights in and out, and for determining necessary quarantine measures when people return home.

'Vaccination is the first step to getting on that plane, and to ensuring Australia reaches a potential herd immunity necessary to allow more people into the country.

'Recent outbreaks in Victoria and New South Wales have shown that our reality can change on a dime, even in a country with low case numbers. Each of us can be exposed and infect others. Vaccination mitigates the effect on us as individuals, as family members and colleagues, and, as has been seen in countries like the UK and US, will increase Australia's capacity to cope with another wave.'

Dr Moy says that despite the challenges presented by the changes in advice from ATAGI, GPs will continue to put patients first and support them in making informed decisions about vaccination to protect them against COVID-19.

EXTRA FUNDING FOR CONSULTATIONS

Dr Moy says the announcement by the Federal Government, based on AMA advice, of extra funding for longer GP consultations related to COVID-19 vaccination will be vital in supporting GPs and their colleagues.

'I know from my own practice that any change in advice leads to people cancelling bookings and urgently seeking advice, so that we all have had to spend much more time talking to patients with concerns. We are in the best place to do this, but we need the appropriate support.'

He reinforced comments by AMA President Dr Omar Khorshid on Friday, 18 June, that the announcement by the Minister for Health, Greg Hunt, would allow GPs to spend more time with patients to ensure that they were aware of all the benefits of a COVID-19 vaccination, and boost confidence in the vaccine.

Dr Khorshid said he had been raising the need for doctors to spend more time with patients with the Prime Minister and the Minister for Health for several months, and was pleased with the Government's announcement of a new level B equivalent Medicare item that could be used in addition to the standard COVID-19 assessment items for patients who require longer consultations.

Dr Khorshid said overseas evidence clearly showed that two doses of AstraZeneca were needed to protect people against COVID-19 variants, including the Delta strain, and confirmed that the risk of blood clotting on second doses was very low: one-tenth the already extremely small risk of the first dose.

'We commend the Minister for Health on this announcement because it is a big step in allowing doctors to take the time to sit down and discuss fully with their patients, some of whom are nervous, the benefits and incredibly low risks associated with vaccination.

'This announcement is particularly timely given the ATAGI decision to change its guidance and lift the age for the AstraZeneca vaccine to 60 years and over.

It is an investment in the vaccination program roll-out, which is so important for Australia in getting on top of the pandemic and plugging gaps in the vaccination rollout.'

'Some patients are understandably concerned following ATAGI's decision and the Federal Government's announcement today will allow doctors to spend the extra time needed with a patient to have a more in-depth discussion about getting vaccinated, instead of putting a decision on hold or deciding not to get a second dose of AstraZeneca.'

Dr Khorshid said the AMA will continue to work closely with the Federal Government to progressively roll out the Pfizer vaccine in general practice in July.

Advocacy leads to aged visit funding

The AMA has also welcomed the Government's announcement of new Medicare funding for GPs to vaccinate patients against COVID-19 during home visits and visits to aged care facilities.

'It is critical we complete the job of vaccinating the most vulnerable in the community as soon as possible. This measure will help plug the current gaps in COVID vaccination in aged care facilities,' President Dr Omar Khorshid says.

He says the new funding announced by Minister Hunt for GPs to vaccinate Australians in residential aged care and at home provides a mechanism to vaccinate residents and workers who missed out in the first round or who have entered a facility recently.

'Residential aged care homes have seen significant COVID outbreaks, and it is important vaccination rates remain very high in these facilities to keep residents safe,' Dr Khorshid says.

'It will now also be easier for patients to get vaccinated when they cannot get to their local GP. This will help those with mobility problems unable to leave their homes easily and support more people in disability accommodation access vaccination via a GP.'

Dr Khorshid says the new Medicare items will ensure new residents entering aged care can access vaccination through their usual GP, or a GP organised by the facility, ensuring the ongoing protection of all vulnerable Australians living in aged care.

ATAGI decision considered risks and benefits

The Australian Technical Advisory Group on Immunisation (ATAGI) on 17 June 2021 recommended the COVID-19 Pfizer vaccine (Comirnaty) as the preferred vaccine for those aged 16 to under 60 years in Australia.[1]

The advice updated the previous preferential recommendation for Pfizer over AstraZeneca in those aged 16 to under 50 years. The recommendation is revised due to a higher risk and observed severity of thrombosis and thrombocytopenia syndrome (TTS) related to the use of AstraZeneca COVID-19 vaccine observed in Australia in the 50-59 years age group than reported internationally and initially estimated in Australia.

For those aged 60 years and above, the individual benefits of receiving a COVID-19 vaccine are greater than in younger people. The risks of severe outcomes with COVID-19 increase with age and are particularly high in older unvaccinated individuals. The benefit of vaccination in preventing COVID-19 with COVID-19 Vaccine AstraZeneca outweighs the risk of TTS in this age group and underpins its ongoing use in this age group.

ATAGI advice recommends that people of any age without contraindications who have had their first dose of AstraZeneca without any serious adverse events should receive a second dose of the same vaccine. This is UK data indicating a substantially lower rate of TTS following a second COVID-19 Vaccine AstraZeneca dose in the United Kingdom (UK).

The ATAGI advice indicated that the decision was made after considering:

- the potential risk of severe illness and death from COVID-19 over the coming months
- minimising harms to people due to adverse events following immunisation
- Australian data on the age-specific risks and severity of TTS following AstraZeneca vaccination
- the expected vaccine supply over the months ahead
- the impacts of any change in recommendation on the COVID-19 vaccine rollout.

The advice noted that there is 'an ever-present risk of COVID-19' in Australia while the population remains largely susceptible to infection. 'Recent events in Victoria have demonstrated how rapidly outbreaks can spread despite intensive contact tracing and public health action. As at 16 June 2021, 63 per cent of Australians aged 70 years and older and 25 per cent of those aged 18 years and older had received at least one dose of a COVID-19 vaccine.'

Risk of TTS from AstraZeneca dose[2]

Age	Estimated risk of TTS per 100,000 AstraZeneca vaccine doses (first dose)
<50 years	3.1
50-59 years	2.7
60-69 years	1.4
70-79 years	1.8
80+ years	1.9

1, 2 ATAGI statement on revised recommendations on the use of COVID-19 Vaccine AstraZeneca, 17 June 2021 | Australian Government Department of Health

In the spotlight

The 2021 AMA(SA) Gala Dinner was a different, but no less memorable, 'night of nights'.

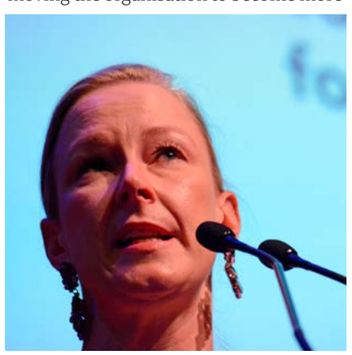
AMA(SA) award winners Dr Danny Byrne, Assoc Prof Rosalie Grivell, Dr Hannah Szewczyk and Mrs Claudia Baccanello

The COVID-19 pandemic triggered a dramatic change in format for the AMA(SA) Gala Dinner. But with ABC 7.30 presenter Leigh Sales as guest speaker, and the handing over of the presidency from Dr Chris Moy to Dr Michelle Atchison, as highlights, the sold-out event at the Adelaide Town Hall on 22 May was as successful as any Broadway-like song-and-dance production.

Ms Sales gave a thought-provoking picture of the heart-wrenching interviews undertaken for her best-selling book *Any Ordinary Day,* and the resilience required of people such as Stuart Diver to overcome personal tragedy. MC Neil Cross of the ABC then quizzed Ms Sales about what she has learned, and whether she would do her job differently, now she has more understanding of the people thrust into the media's glare.

Outgoing President Dr Chris Moy offered some thoughts for his audience as he reflected on a term of unpredictable challenges and health-related headlines.

'Two years ago, some of you may remember that I stood here admitting that I'd been reluctant in taking up this job,' Dr Moy said. 'But, if I was going to do it, I was going to do my best to focus on moving the organisation to become more outward looking and modern, but in a way that was inclusive, welcoming and approachable, that would respect the achievements of our past, but also connect this with the energy and spirit of our future: our younger upcoming doctors and medical students.



Gala Dinner guest speaker Leigh Sales AM

'I got to realise that being calculating about achievement is a hollow path. There is no fun in just notching up wins. The real satisfaction and joy was in the journey, and in having the good fortune to cross paths and work with the good people that I was privileged to meet along the way.'

A major feature of the evening was the presentation of the 2020 AMA(SA) Awards, with recipients chosen in the final weeks of Dr Moy's presidency. Dr Moy's citations included the following remarks.

AMA(SA) MEDICAL EDUCATOR AWARD – DR DANNY BYRNE

"The 2020 recipient of the AMA(SA) Medical Educator Award has had a life-long professional commitment to teaching undergraduate and post-graduate medical students, GP colleagues and international Medical Graduates, and has hosted students in GP placements since 1995.

This springs from a passion for general practice and a desire to share its secrets and delights – particularly the longitudinal relationship with patients and their families – to new generations of doctors.

Nearly every GP who has come through the GP training program in SA knows him. Perhaps that's because humor and humility is a trademark of his teaching. Certainly, those who saw him appear as Iron Man at the RACGP Conference to present on iron infusions will never forget it.

South Australia's Chief Public Health Officer Prof Nicola Spurrier

It's also symbolic of his passion for supporting GPs. He is a skilled communicator, teaching across a range of topics from digital health to dermatology.

He's recognised as a fabulous team player – in his own practice and in the various collaborative iterations of Commonwealth-funded GP organisations.

He's also very involved in supporting international graduates to obtain GP Fellowship, helping them safely practice medicine in rural and remote areas and navigate the even stranger cultural and bureaucratic terrain of the Australian health system.

Most importantly, he is the most recognised GP in SA in being the Chair of the SA/NT Faculty of the RACGP for many years. And, on a personal level, he's been an inspiring colleague."

AMA(SA) CEO Dr Samantha Mead, President Dr Michelle Atchison and Executive Assistant Mrs Claudia Baccanello, with Deputy Premier Vickie Chapman and Health and Wellbeing Minister Stephen Wade

PRESIDENT'S MEDICAL LEADER AWARD – DR HANNAH SZEWCZYK

"Our next award – the President's Medical Leader Award – is for demonstrating leadership among their medical peers.

This year, it goes to a person who has really stood up to support her peers at a point in her career when many simply keep their head down. She has been a voice for those with limited influence in the hospital system and, in a calm, committed way, has spoken truth to power and effected significant transformation in the treatment of doctors in training.

Though only in the early stages of her medical career, the recipient has served in a range of key leadership roles for the AMA(SA), rebuilding the almost inactive Doctors in Training Committee to become an engaged group that continues to grow and exert its influence within the health system and the AMA, in this state and federally.

Her role in supporting and driving change in the experience of doctors in training was pivotal – especially in managing the Doctors in Training Hospital Health Check Survey (that) contributed to the important changes achieved from that Summit.

She has served on Federal Council this year and she is an active member of the AMA Equity Inclusion and Diversity Committee.

She has been outstanding in her contributions and leadership and she has done this with genuine humility and in a manner that always has been inclusive and approachable."

AMA(SA) AWARD FOR OUTSTANDING CONTRIBUTION TO MEDICINE – ASSOCIATE PROFESSOR ROSALIE GRIVELL

"The winner of the 2021 award for her outstanding contribution to medicine is someone (who took on) a role previously unknown to her as she presented evidence-based reason about the plight of women to advocate calmly yet powerfully for the long overdue overhaul of South Australia's abortion laws.

Her capacity to present her knowledge and experience in her field in the face of passionately held views helped move South Australian policy from the realm of criminal law to health policy. She responded to calls for advice at all hours of the day and night as the Termination of Pregnancy Bill 2020 was debated.

She is a consultant obstetrician and maternal fetal medicine subspecialist at Flinders Medical Centre and Matthew Flinders Fellow in Maternal Fetal Medicine at Flinders University.

As Director of the Medical Program for the College of Medicine and Public Health at Flinders, she provides academic leadership in inspiring and innovative teaching and her research interests focus on clinical research in high-risk pregnancy, systematic reviews and meta-analysis and the use of clinical data to improve health outcomes. She was instrumental in positively bringing together teaching at Flinders Medical School after a very difficult period, and guided the program as the pandemic brought so many changes.

She has received a number of professional awards and scholarships but her role in the abortion debate was a test of mettle."

MC Neil Cross

AMA(SA) Outstanding Achievement Award – Mrs Claudia Baccanello

"The AMA(SA) Outstanding Achievement Award is presented to an individual for an outstanding contribution to AMA(SA) and, as such, is not presented every year.

However, the committee was unanimous in deciding on a recipient of this award.

This individual has been not only the face of the AMA(SA) for over 15 years, but also displayed the genuine loyalty, commitment, decency and humility to which we all aspire.

For my part, and I suspect every other president in recent times, this individual has been the one who has held us together through our official exploits, and also the one to gently remind us of the little courtesies that make the difference in maintaining good relationships.

More importantly, this much-loved person embodies the values of the AMA and has, for all the time that I can remember, been its memory and its heart and soul."

AMA(SA) President Dr Michelle Atchison addressing the AMA(SA) Gala Dinner audience

Stepping up, speaking out

As Chair of the AMA(SA) Council, Dr Michelle Atchison insisted on acknowledging Country in the Kaurna language. In repeating the acknowledgement to begin her first public speech as President, Dr Atchison set the scene for a sensitive, inclusive and insightful presidency.

"It makes me very happy to be able to stand here – in person! – to greet you and thank you for the support I've received coming into this important position.

It is especially important that I have this opportunity to publicly thank outgoing President Dr Chris Moy for all he has done for the AMA, for our members and for all South Australians, as President of the AMA in South Australia.

It's rare – perhaps unknown – to have an AMA President in this state who has literally become a household name; whose voice and face are recognised and known. That profile has come because of Chris's willingness to speak clearly, openly and often about the health issues that have been so prevalent – in fact, all-consuming – during his presidency.

Policymakers, the media, the public who call into his regular session on ABC radio every Saturday morning – they all know that they will receive information from the voice of the AMA that they can understand and trust.

Thank you, Chris, for leaving AMA(SA) in such good shape. You have raised the profile of our organisation with doctors and the public, and reinforced the good relationships with government and other organisations that built on the excellent work of our previous President, Associate Professor William Tam.

I can only promise to do my best to fill his very big shoes.

Many of you know me through our professional dealings or through my position as Vice President and in other AMA and College of Psychiatrists' roles.

For those who don't, though, a little about myself.

I am a psychiatrist who has worked in private practice in the inner suburbs for nearly 25 years. I specialise in the treatment of psychological trauma, including the trauma of veterans of armed conflicts.

I am married, and share a practice with, my husband Barry, and have a grown-up daughter (both of whom I'll thank now for past and future patience and support!).

I grew up in a very non-medical family of artists. My father was well known as the editorial cartoonist for The Advertiser for nearly 40 years. It was always a great surprise to my parents that they ended up with a doctor and a lawyer (my sister).

Growing up in the Adelaide Hills, and going to the local high school (when my father taught art at Pembroke), has given me a great life experience across friends who left in Year 10 to work on farms, to fellow students who went on to medicine. I think this has helped me in psychiatry to understand people from all walks of life.

I studied medicine at Flinders, where I took advantage of its innovative program structure at the time and included studies in visual arts and Spanish alongside genetics and cell structure.

After graduation, I interned at the RAH – and quickly gained a very different picture of the health system than the one I was exposed to during my student years.

WHY PSYCHIATRY?

Psychiatry gave me my 'ah ha' moment in medical training with great mentors at Flinders Medical Centre. It has been a great career for work-life balance, and I have never felt discriminated against for being a woman in medicine in this profession.

But my husband is also a psychiatrist, so our poor daughter has had to grow up with a life of 'don't analyse me!'.

Outgoing President Dr Chris Moy presents Dr Atchison with the President's Medal

I love travel (sigh), reading and watching science fiction, playing bridge and I have a second degree in shopping, as my husband may attend to!

I am, like Chris, a passionate supporter of the Adelaide Crows. And I have an abiding love of the visual arts; if I had my career again, I would be buying art for medical rooms or travelling the galleries of the world.

I've never regretted my career choice. But I have had reason to despair at a society that continues to stigmatise and dehumanise people with mental health issues in a way that people with other health issues are not discriminated against.

I have seen the impacts of a health system that cannot manage the number and needs of mental health patients.

I have attempted to help people who feel overwhelmed by their illness when there has often been an apparent unwillingness of others to understand and help.

I have already stepped into the discussion on our fracturing mental health services, and you will see and hear me speaking on these issues, as your president.

But improving outcomes for South Australians with mental health issues is only one of my priorities. I will be leading AMA(SA) efforts to guarantee that clinicians have appropriate input into planning for the new Women's and Children's Hospital – and that the health needs of some of our state's most vulnerable people are met while we wait for that hospital to open.

This means working with government to ensure clinicians' knowledge and experience are included in planning processes, and that our predictions for future demand are addressed.

I will advocate for the issues facing members and healthcare across South Australia including in both the public and private systems – and with the understanding that while each has its issues, the problems of one have direct and indirect ramifications for the other, and for our whole health system.

I will be the voice and face of an AMA(SA) that – in being the only organisation for all South Australian doctors – must be involved in, must monitor and must respond to the many decisions that are yet to be made, as we remain in, and then emerge from, the pandemic. These are decisions that affect each of us as doctors, business owners, patients and carers.

On a drier note, I look forward to continuing the work that is underway with our CEO Dr Samantha Mead and our Board to change our constitution, so the AMA in this state has a foundation from which to make strong, evidence-informed decisions about the issues that confront us today and will confront us tomorrow. And so our Council and our AMA is reconfigured to encourage junior doctors – male and female, recent students and those with years of experience – to be involved in our advocacy and hopefully look at representing their peers at a leadership level.

It is shocking that we still have to have conversations about gender diversity in our profession – but it is clear from the representation in this room, and in AMA committees, that the times are changing.

Developing leadership in our new career doctors is a particular passion of mine, and I am looking forward to using this platform to help the next generation of doctors consider opportunities to lead in the many different spheres that exist within health workplaces and networks.

I am pleased and proud to be President of the AMA in South Australia. This is an organisation that in the past 18 months alone has:

- *hosted a Culture and Bullying Summit that has directly led to legislative reform, placing responsibility for the safety of health workers with Local Health Network Boards*
- *had a direct impact on conversations, debate and legislative proposals that have to the long-overdue decriminalisation of termination of pregnancy in this state*
- *had a direct impact on the wording of an amendment to proposed Voluntary Assisted Dying legislation that provides additional – and possibly unique – protections for doctors and patients, and*
- *has argued and campaigned for and ultimately directly led to many of the policies and conditions to help us as doctors to help our patients throughout one of the most difficult, prolonged periods of health distress in our nation's history.*

I could not be prouder of this organisation and its members, who have worked so hard for patients and communities,and in doing so have engendered, renewed and reinforced the community trust in our profession.

I will continue the legacy of Chris and those before him, and be an independent voice of reason in advocating for better healthcare, better services, and better outcomes for our patients and for those who need our voice.

I will be accessible – to government, to media, to members who, when asking who can answer a medical question or clarify a health policy, thinks first of the AMA.

I will be asking you to help me – to inform me, or other Councillors or the Secretariat, of the problems that reduce access to care, or affect the quality of care.

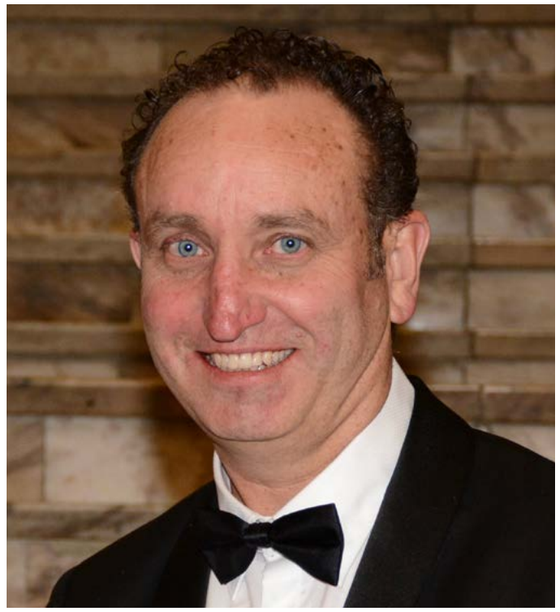
My profession has taught me to listen carefully, but it has also taught me when it is time to stand up and act.

Thank you."

LEADERSHIP

Primary motives

New Vice President Dr John Williams is believed to be AMA(SA)'s first country-based VP. Here, Dr Williams answers some questions about why he's in the AMA and what inspires him.



New AMA(SA) Vice President Dr John Williams at the Gala Dinner on 22 May

When and why did you decide to become a doctor?

I decided as I filled out my university application – I did not expect to get into medicine.

Where did you study?

I completed medical school at the University of Adelaide, then interned at Modbury hospital. I was a resident at WCH, did obstetrics and gynaecology at Flinders Medical Centre, and GP training at Strathalbyn and in metropolitan Adelaide. I was a house officer in plastics and emergency medicine, and did more GP training, in the UK, and added a Master's in medicine via distance education from the University of Queensland. There's a music qualification from Adelaide, too.

What are the key priorities for the AMA and for rural health?

Health has some major gaps. We know the solutions, but there are some barriers to putting things in place. If our health as a community is to improve, the most efficient and effective place to do this is in primary care. Primary care has real roles in supporting mental health, aged care, chronic disease.

Why are you a member of the AMA?

I joined as a medical student and continued. What cemented my involvement in the AMA was when I was invited as a young GP to go with a group of other GPs from around the country to Canberra. I saw first-hand the influence the AMA had and how it actively advocated for the health system and doctors.

What have been the main impacts of the pandemic on you and your community?

The COVID pandemic has had a great impact. We have been lucky in Port Lincoln – along with the rest of South Australia – that we have had little in the way of lockdowns. What it has done for us as rural doctors, is make us even more acutely aware of the fragility of rural health. We have all seen incidents which have brought our local health systems to their limits and beyond. There is no redundancy in rural.

What excites you about medicine today?

It is no secret or mystery that primary care is the place to cost effectively improve the health of our community. I would be excited to see general practice lead and help build this. There is also a growing understanding in medicine of what compassion is, in very real terms. It is a specific skill set that can be learned and taught. Compassion is an artform of its own and I am truly a novice. Again, I see GPs in an ideal place to lead this.

What stresses or distresses you about medicine today?

My greatest stress and distress is when common sense seems to take second place to other pressures. I do not wish to be part of a generation that is looked upon as the generation that let common sense die. By common sense, I guess I mean procedures and processes that are directly designed to assist health workers with patient care. There seem to be many procedures and processes that actually make patient care more difficult.

What made you choose general practice – and then rural practice?

I enjoyed the variety of work in general practice, especially rural.

Why have you chosen to live and practise in Port Lincoln?

My wife is from Port Lincoln and my parents retired to Port Lincoln. It's a very beautiful place with a great community: earthy people – farmers, fishers – everyone is very connected to the surroundings. It's a perfect place to raise a child – less than five-minute commute; beaches, national parks on your doorstep; cycling, bush walking, boating, fishing.

What do you do in your spare time?

I love spending time with family and friends. And this often involves music. I'm a musician. Music is great – creative, expressive. It engages my whole brain and helps it work as a whole and more effectively. I know music makes me a better doctor. I also love reading. The arts give me the tools to wade in to the difficult and undefinable aspects of medicine with, I hope, some bravery and open mindedness. And when it's possible, we love to travel.

RESEARCH

Research finds a paradox

Research into breast cancer survival rates is finding that obesity has a complex role.

Dr Ashley Hopkins

Mr Natansh Modi

Medical researchers at Flinders University have identified a weight-related paradox in breast cancer survival rates, observing that a high body-mass index is linked to poor outcomes in the early stages of breast cancer but better survival rates in advanced breast cancer.

This builds on other research that indicates a BMI paradox in cancer survival rates among people with lung cancer.

The study[1] evaluated data from clinical trials involving patients with human epidermal growth receptor 2 (HER2)-positive breast cancer as a first step in understanding the biological impact of obesity on survival rates in different stages of the disease.

Flinders University researchers NHMRC PhD candidate Natansh Modi and Dr Ashley Hopkins say it is hoped this insight will lead to the development of more effective treatments.

The study included 5,099 patients with early breast cancer and 3,496 with advanced breast cancer.

It found pre-treatment overweight/obese BMI was independently associated with worse survival outcomes in HER2-positive early breast cancer. However, pre-treatment overweight/obese BMI was independently associated with improved survival outcomes in HER2-positive advanced breast cancer.

The results indicated a marked obesity paradox in HER2-positive breast cancer, which was consistent regardless of the use of contemporary therapy or the line of therapy.

'Higher body-mass index is associated with an increased risk of developing many types of cancer, including breast cancer, as a result of elevated levels of circulating sex hormones such as oestrogen, oestrone, and testosterone, high serum leptin, and chronic inflammation that are associated with high BMI,' says Mr Modi, an NHMRC PhD candidate.

The study points to the need for further investigation into the obesity paradox in other breast cancer subtypes, which the unit plans to undertake with data from more than 40 clinical trials.

'The data in this study is only for HER2-positive breast cancer. We haven't looked at all the breast cancer subtypes yet but that's our plan. I'm currently in the process of collecting data from other breast cancer subtypes to see whether this paradox is breast cancer-wide or only limited to HER2-positive cancer,' Mr Modi says. 'Teasing that out will help us understand the biological rationale of obesity effects on survival and prognosis in different subtypes.'

> *'... Access to trials data is often limited due to pharmaceutical company fears about giving away trade secrets and losing market share ...'*

Dr Hopkins says it is less obvious why obesity is associated with survival in advanced breast cancer. At 'face value', he says, the correlation may reflect that those with a higher BMI at the advanced disease stage have a less aggressive form of cancer than those with a low BMI.

'There's a lot of research to go to understand the impacts of hormones,' he says. 'At its most basic, we presume that people who are losing weight and thus have a lower BMI are people with more aggressive disease.'

The study is an important step in improving treatment outcomes for the almost 20,000 women and 160+ men diagnosed with breast cancer in Australia.[2]

'This is world-first evidence of an obesity paradox in breast cancer and the long-term objectives are multifaceted,' Dr Hopkins says. 'It's about informing biological insights around particular medicines that might not be working as well in people with high and low BMI, as well as demonstrating the importance of data transparency by the pharmaceutical industry.

'As we begin to pool studies from many, many trials we will be able to explore longitudinal data to observe the obesity paradox and the underlying biological rationale.'

The project also highlights the importance of data transparency in clinical trials, say the researchers. Access to trials data is often limited due to pharmaceutical company fears about giving away trade secrets and losing market share.

'At the moment we only are able to access a fraction of the clinical trials being conducted in breast cancer, yet this project demonstrates an ability to tease out important information – information that is important to patients and information that enables researchers to tease out biological insights,' Dr Hopkins says.

[1] N Modi, J.Q.E. Tan, A. Rowland, B. Koczwara, A. Y. Abuhelwa, G. Kichenadasse, R. A. McKinnon, M. D. Wiese, M. J. Sorich and A. M. Hopkins The Obesity Paradox in early and advanced HER2 positive breast cancer: pooled analysis of clinical trial data', npj Breast Cancer (2021) 7:30; https://doi.org/10.1038/s41523-021-00241-9

[2] 2020 figures

To serve and protect

After 16 attempts, the South Australian Parliament has passed a Bill to legalise voluntary assisted dying. As AMA(SA) President until early May, Dr Chris Moy was a key participant in discussions to ensure the legislation was best able to both serve and protect patients and their doctors.

AMA(SA) Immediate Past President Dr Chris Moy

In the early hours of 10 June, the Lower House of the South Australian Parliament voted 33-11 for legislation to introduce voluntary assisted dying (VAD) to this state. It came after two years of efforts by a majority of parliamentary members to progress legislation modelled on Victorian laws permitting VAD. With the passage of this appearing inevitable, AMA(SA) worked constructively to ensure that any legislation that did eventuate provided protections for doctors and vulnerable patients, and maintained the integrity of palliative care provision and the health system as a whole in line with the 'AMA Position on Euthanasia and Physician Assisted Suicide 2016'.

AMA(SA) involvement in this 17th parliamentary push for VAD or euthanasia began in September 2019, when AMA(SA) Council responded to a request for a submission to the Joint Committee on End of Life Choices. It was clear that the Committee at that time was likely to support VAD legislation; nevertheless, it was important that the AMA reminded the Committee that the parliament should not lose a focus on sufficiently funding palliative care and advice care planning, and should not view any legislation on VAD as the solution to the provision of end-of-life care, which it patently is not. Good end-of-life care is a function of funding and resourcing, and it would be a terrible day for South Australians if VAD became the only option for an individual to obtain comfort and dignity in death due to lack of adequate palliative care funding.

South Australia already has the best legislation in Australia to support good end of life care for individuals and their right to self-determination, in the *Advance Care Directives Act 2013* consolidating the *Consent to Medical Treatment and Palliative Care Act 1995* and the *Guardianship and Administration Act 1993*. It was critical that AMA(SA) reinforced the need for adequate resourcing of palliative care services and advance care planning; and also to make clear to legislators that current legislation allows doctors to provide patients with treatment adequate to provide relief from pain and suffering, even when this may shorten their life.

'… the decision to introduce VAD is itself not a medical issue but a complex social and community one …'

However, as Victoria and then other states have considered and began introducing VAD legislation, it was clear that South Australia would soon follow. The AMA's role, then, was to provide advice to ensure any Bill that did earn support in South Australia be the best legislation possible for doctors and patients. Our submission was followed by a face-to-face statement to the Joint Committee, participation in a physicians' forum that included Health and Wellbeing Minister Stephen Wade, and the provision of sought-after advice relating to 'institutional conscientious objection'. At all times, we were clear that the decision to introduce VAD is itself not a medical issue but a complex social and community one; paradoxically, though, medical practitioners must be the ones to arrange medication to bring about death. As such, individual doctors must have the right to conscientiously object to their involvement.

I must confess to having some frustration while discussing aspects of this Bill, given the wisdom and carefully constructed law that is embedded in pre-existing South Australian legislation. In the *Advance Care Directives Act*, we have one of the most comprehensive pieces of legislation in the world in providing a legally binding 'voice' for individuals, before they lose decision-making capacity. It is widely accepted that more people will seek palliative care than will ever look to VAD options. And yet palliative care continues to be under-resourced to the point that many people don't realise it could be the right option for them; and Advance Care Directives are still not promoted in the way they should be.

But, again, it was clear that after so many failed attempts, the parliament had reached a point where support for VAD legislation was inevitable. As such, AMA(SA), with the support of Palliative Care SA Chair Professor Gregory Crawford, provided advice to Minister Wade regarding an additional clause to make it clear that VAD is *not* palliative care; and that clearly sets out that VAD and palliative care are defined and distinguished by the *intention* of treatment, with the intention of palliative care (and the concept of 'double effect') being solely and directly aimed at treatment and relief of a patient's distressing symptoms, while the intention of VAD is to end an individual's life.

© iStock / Wildpixel

The addition of this amendment enhanced the legislation because it added an explicit reference to Section 17(1) of the *SA Consent to Medical Treatment and Medical Care Act 1995*, which remains the gold standard of legislation in Australian in setting out the protections for medical practitioners providing treatment under the framework of palliative care, and the widely accepted principle of 'double effect' (that is, while providing treatment aimed at the relief of symptoms the medical practitioner does not incur liability where the treatment incidentally, rather than intentionally, hastens the death of a patient.

In arguing for this, we pointed out that Section 10 of the proposed legislation stipulates that VAD must not be initiated by a registered health practitioner. We noted that, in doing so, it is essential that they are also clear that that they can initiate palliative care to relieve the distress symptoms that a patient might be presenting with under the provisions set out in Section 17(1) of the *SA Consent to Medical Treatment and Medical Care Act 1995* because a failure to do so would undermine the patient's care.

Finally, we ensured that in clarifying the difference between palliative care and VAD based on intention, the amendment prevented a 'blurring of the conceptual line' between these two options both in the mind of an individual doctor, but also at the level of community understanding. A slippage in clarity regarding this difference creates the risk of individual health practitioners, or sectors of the community, being able to impose their own values on others – in particular, those most vulnerable in the community (such as aged individuals or those with disabilities) where some may feel that they can make judgements about the value of the lives of these individuals.

'… A slippage in clarity regarding this difference creates the risk of individual health practitioners, or sectors of the community, being able to impose their own values on others …'

And so, we came to the Lower House vote, which – as the deadline for this issue approaches – has just occurred. We haven't yet seen the final legislation, which, because of the amendments, must now go back to the Upper House. Comments from Bill proponent and Shadow Attorney General Susan Close after the vote suggest that there will be provisions to allow some institutions to conscientiously object; the AMA will be carefully monitoring these to ensure that while health institutions should be able to do so, patients will still be able to obtain treatment in line with their own wishes through alternative avenues.

Our advocacy for more palliative care services does not end here. As discussed in our 2019 submission, AMA(SA) calls for a comprehensive plan to increase the resourcing to:

- enhance the capacity of the generalist workforce to provide end of life care in community, aged care and hospital settings
- support specialist palliative care services to deliver equitable, high-quality statewide services and provide support to generalist services
- improve coordination of care between primary care, aged care and specialist services, with a particular need to involve, resource and support general practitioners caring for dying patients in the community.

As I write this, the implications for funding of palliative care, and VAD itself, in the State Budget are not known. *medic*SA will examine the ramifications in future editions. The AMA position is, and will continue to be:

1.5 Access to timely, good quality end of life and palliative care can vary throughout Australia. As a society, we must ensure that no individual requests euthanasia or physician assisted suicide simply because they are unable to access this care.

3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.

MBS changes create chaos

AMA President Dr Omar Khorsid at the National Press Club on 9 June 2021

Private surgery patients face a period of turmoil as the biggest changes to Medicare in decades are rushed through for the new financial year, the AMA is warning.

AMA President Dr Omar Khorshid says poor implementation of the changes to nearly 1,000 Medicare Benefits Schedule (MBS) rebates for private surgery, scheduled to be introduced on 1 July, is likely to result in chaos for patients – a repeat of the trials associated with the first tranche of changes in 2018.

With private health insurers left with little time to update their fee schedules following the government's changes, patients will be left in the dark about their rebate for procedures.

'We are seeing the biggest changes to the MBS ever with only a few weeks' notice and not enough information for doctors to be able to use those numbers properly,' Dr Khorshid says.

'The AMA has been supportive of the MBS review changes thinking it's good to make our schedule fit-for-purpose for the future. But we feel very let down when the implementation is so poorly handled. ... The AMA has written to the government on a number of occasions. We've even proposed a statement of principles about how these changes should be implemented.

'It's almost like wilful incompetence on behalf of government, given they've been warned so clearly.'

The changes include new items, changed items and changes around rules governing the way doctors use the items – including not allowing doctors to use multiple items to describe one operation.

The rules and descriptions have not yet been released, leaving doctors and health funds no time to adjust their fee schedule accordingly, Dr Khorshid says.

'It's pretty simple to give all the players enough time to cope with the huge amount of change. It doesn't undermine the MBS schedule at all. It doesn't change the financial outcomes, doesn't change the government's spending on health. It's just paying respect to the industry, to the hospitals, the doctors, insurers and patients.'

Patients worst affected by the changes next month are in areas such as hip arthroscopy as changes to the MBS mean patients will be potentially thousands of dollars out of pocket with no clear way forward, he says.

In this case, and in a number of other areas of orthopaedic surgery, the gaps – likely to be a couple of thousand dollars - are likely to make this surgery out of reach for some Australians covered by private health insurance.

This would lead to patients unjustifiably feeling let down by their doctors and by health funds. Insurance systems such as the workers' compensation insurance systems which used the AMA schedule of fees to set their fees would have to wait until after September to have certainty about fees.

'After the spinal surgery debacle of 2018, the AMA and the private health sector told the Department of Health that six months' lead time is needed ahead of MBS changes,' Dr Khorshid says.

'More than two years later, we are facing the same problems, but with more than 10-fold the volume and complexity.

'This will put significant financial and operational risk on health insurers and private hospitals, and leaves doctors and patients scrambling and confused about what and how to bill against Medicare and private health insurance policies come 1 July.'

Dr Khoshid says doctors did not know what the rebates from funds will be, as they haven't had the time to prepare and release them in advance – including for surgeries already booked for next month.

> ***'... The AMA is calling on the government to urgently commit to changing the process going forward to avoid past problems ...'***

'The government's reminder to doctors to consider patients' circumstances when charging fees misses the point. At the moment there's no way for doctors to know if they are charging a gap due to the chaos caused by the department's poor implementation.

'The AMA is calling on the government to urgently commit to changing the process going forward to avoid past problems, and ensure that this massive change to MBS rebates occurs without disruption to patient care.

'We are also calling on the government and private health insurers to safeguard patient private health insurance rebates, to ensure that they are not worse off financially, for undergoing orthopaedic, general or cardiac surgery after 1 July due to implementation issues with the MBS.'

Momentum for change

Increasing awareness of workplace cultural issues has brought little change for junior doctors – yet. Former AMA(SA) Doctors in Training Chair Dr Hannah Szewczyk analyses the results of the 2020 Hospital Health Check.

Former AMA(SA) DiT Committee Chair Dr Hannah Szewczyk

In November 2020, the AMA(SA) Doctors in Training Committee ran the second annual Hospital Health Check (HHC) Survey in South Australia. The HHC is a survey for doctors in training containing questions about working hours and overtime, fatigue, access to leave, workplace culture, bullying and harassment. In 2020 there were also questions related to COVID-19, including employer communication and support, and access to PPE and fit-testing.

Similar HHC surveys are conducted by state and territory AMAs every year, providing opportunities to not only compare how South Australian hospitals perform against each other, but also how they stack up against hospitals around the country.

The survey is open to all doctors in training, from interns to senior registrars, regardless of whether they are AMA members.

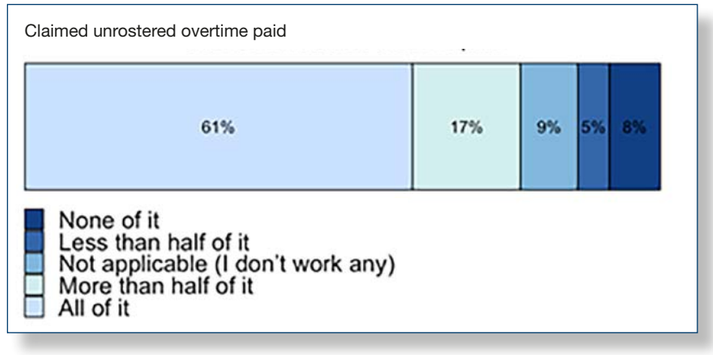
In 2020 we had a relatively low response rate, with 109 doctors in training completing the survey. We postulate that this may be due to the significant distractions and other priorities that doctors in training were experiencing at the time due to COVID-19, and particularly the impact the pandemic had on assessment and training; for example, multiple examinations being cancelled at short notice or being switched to malfunctioning online formats.

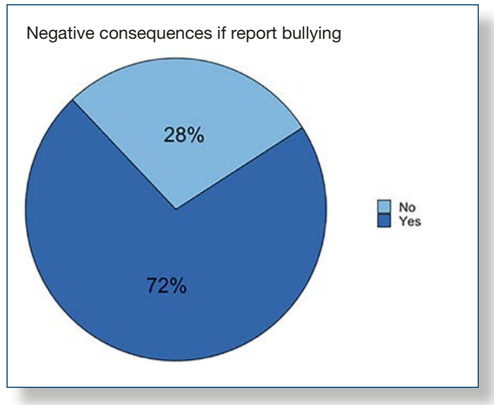
Despite the smaller response rate, the results were unsurprising and similar to 2019's results. High levels of unrostered overtime, fatigue, and personal experiences of bullying and harassment were reported. Many respondents stated they had been advised not to claim overtime, with one saying 'my time sheet was changed and "corrected" by admin to add in breaks and take off overtime before it was signed by the head of unit'. Concerningly, most respondents from all four major hospitals reported concerns about personal safety or fear of making clinical errors due to fatigue. This is not just a workplace issue but a patient and public safety issue.

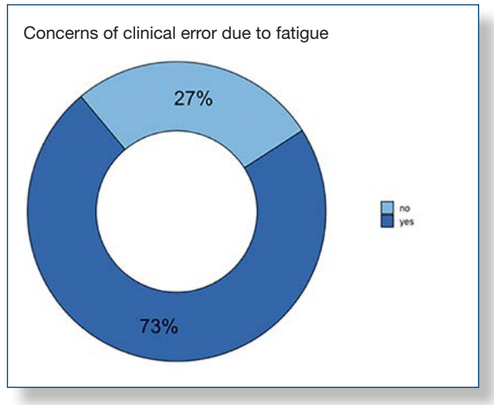
In addition to the unacceptably high rates of reported bullying and harassment is the fact that most respondents are concerned that reporting these experiences would lead to negative workplace consequences. This further highlights the long ingrained cultural issues of the medical hierarchy, and that doctors often feel they must tolerate being mistreated at work to get into or through their training. This is compounded but the lack of structural support, meaning that many trainees don't believe they have anyone to whom they can report bullying, without the alleged perpetrator or perpetrators finding out. When these alleged perpetrators are the supervisors, employers, assessors, teachers and referees of the doctors in training, the stakes are high.

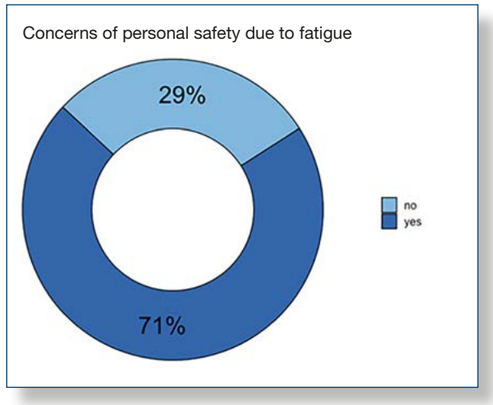
There is increased awareness and discussion of issues such as poor workplace culture, unpaid overtime, fatigue, and burnout for doctors in training. The 2019 HHC results were used to drive the AMA(SA) Culture and Bullying Summit, which was held in February 2020 and led to changes in legislation so that Local Health Network Boards are now legally responsible for the health and wellbeing of their staff. I hope that with these changes and an ongoing appetite for improving working conditions and culture in medicine, we will see improvements quickly and in the years to come.

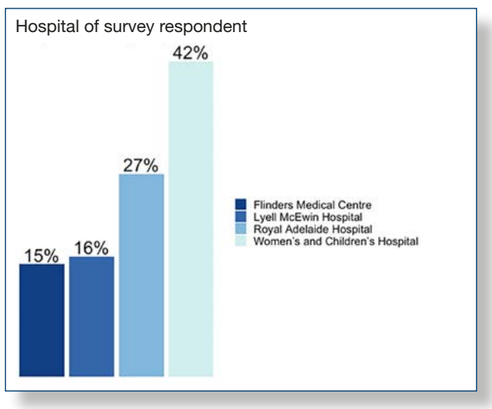
The AMA(SA) will continue to conduct the HHC survey annually to measure and assess where positive changes are occurring, and where they are not.

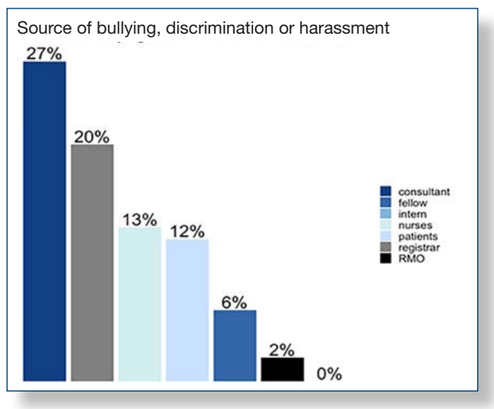


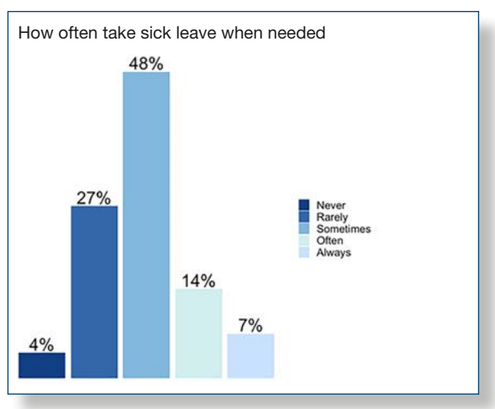


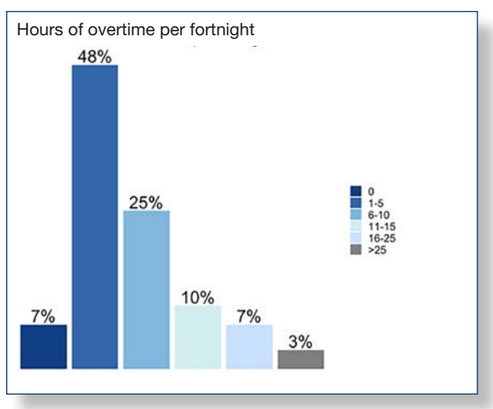












ADVOCACY

Not so sweet

A tax on sugar is one of the measures announced in the *AMA's Vision for Australia's Health*, released by Federal AMA President Dr Omar Khorshid this month.

The AMA is again urging policy makers to introduce a tax on non-alcoholic, high-calorie drinks, in a campaign to reduce the impact of chronic diseases associated with obesity.

AMA President Dr Omar Khorshid told the National Press Club on 9 June that the strategy would be an important tool in the fight against diseases such as type 2 diabetes, heart disease, cancer, tooth decay and more. This would bring Australia in line with 45 countries that have introduced sugar taxes, leading to observed improvements in obesity rates.

The tax was announced along with the *AMA's Vision for Australia's Health*, a 42-page document that outlines policies in five pillars: general practice, public hospitals, private health, 'a health system for all', and 'a health system for the future'. (*medic*SA will outline the policies and vision in detail in the August edition.)

Dr Khorshid told the Press Club audience that a recent study commissioned by the AMA has found a sugar tax on selected sugary drinks would reduce consumption by 12-18 per cent, with significant benefits for government revenue and reduced health care costs.

Dr Khorshid said adult obesity rates in Australia had risen over the past 25 years from 19 per cent to 31 per cent, while obesity in children had increased from 5 per cent to 8 per cent, reflecting the fact that high-calorie, low-nutrition foods were increasingly available.

'Australians drink at least 2.4 billion litres of sugary drinks every year – that's enough to fill 960 Olympic-sized swimming pools,' Dr Khorshid told the Press Club audience. 'Young males are the biggest consumers.'

The AMA is concerned that around a third of the adult population is likely to be obese by 2025, leading to an increase in diseases such as type 2 diabetes, heart disease, stroke and cancer.

'Sugar-sweetened beverages are a major contributor to the obesity crisis and provide almost no nutritional benefit,' he said. 'These drinks contain free sugars such as sucrose, high-fructose corn syrup or fruit juice.

'If no action is taken to stem the obesity crisis by 2025, taxpayers will have spent an additional $29.5 billion in direct healthcare costs of obesity.

'A systematic review of worldwide costing studies estimated that people living with obesity have medical costs that are approximately 30 per cent percent greater than their healthy-weight peers.

'There is a strong association between sugar-sweetened beverage consumption and increased energy intake, weight gain and obesity. Conversely, reduced consumption of (these beverages) is significantly associated with weight loss,' Dr Khorshid said.

The AMA proposes a tax on a subset of sugar-sweetened beverages that provide no nutritional benefit, including all non-alcoholic drinks containing free sugars. The tax would not apply to 100 per cent fruit juice, milk-based and cordial drinks.

The AMA study modelled an excise tax based on sugar content in line with World Health Organisation recommendations to raise the retail price by at least 20 per cent – a tax rate of 40c/100g sugar.

Previous modelling has found that a tax on selected soft drinks is likely to raise annual government revenue of between $749 million and $814 million. The AMA study suggested this could be achieved without a significant impact on the domestic sugar industry because 80 per cent of Australian-produced sugar is exported and only 5.3 per cent of total domestic production contributes to making sugar-sweetened beverages in Australia.

'For the benefit of doctors, patients and broader society, there is a clear imperative to act now to arrest the growing obesity crisis – a crisis that places a huge financial burden on our health system, in particular our public hospitals,' Dr Khorshid said.

'A tax on sugar-sweetened beverages would be a targeted and sensible first step towards improving diets and thereby tackling obesity, which would relieve pressure on our public hospitals in the long term without draining any existing resource from the health budget in the short term,' the AMA study says.

While the study notes that a sugar tax is potentially regressive, affecting members of low-income groups who spend more of their income on these drinks, availability of a direct substitute (water) would counteract this effect. Furthermore, as lower income groups are the greatest consumers of sugary drinks, health benefits accruing to this cohort would be disproportionally high.

The AMA's support for a sugar tax on selected drinks is backed by the Australian Dental Association, which says the revenue raised by such a tax should contribute to an Australian Dental Health Plan (ADHP).

'If, for consumers, drinking sugary soft drinks is disincentivised by making them more expensive, it will go some way to reducing sugar consumption and its disastrous knock-on effect for oral health and whole of body health,' ADA President Dr Mark Hutton said after the AMA policy was released.

ADA surveys show 47 per cent of Australian adults consume much more than the six teaspoons of sugar a day that is recommended to prevent tooth decay. Many are not aware that a 250ml container of soft drink contains an average 10 teaspoons of sugar.

A sugar tax of soft drinks has so far been sidelined in Australia by a voluntary pledge from the soft drinks industry to reduce sugar sold in beverages by 20 per cent over a decade.

RESEARCH

New treatments offer hope

Women's and Children's Hospital dermatologist Dr Lachlan Warren says new treatments may change the lives of people with chronic skin conditions – if they can access specialist care.

Dr Lachlan Warren

Revolutionary targeted therapies are offering new hope to people suffering from debilitating immune-based skin conditions, says Dermatology Unit Medical Head at the Women's & Children's Hospital, Dr Lachlan Warren.

Yet access to dermatology generally remains limited for many community and public hospital patients – especially in the northern areas of Adelaide and in regional areas, he warns.

Dermatology is experiencing a watershed moment with innovative treatments for chronic skin conditions that for many people suffering them have not only been painful but have caused social and economic exclusion over many years.

Dr Warren says novel new treatments – and their inclusion on the Pharmaceutical Benefits Scheme (PBS) – are life-changing for people living with conditions such as psoriasis, eczema or atopic dermatitis, chronic urticaria and hidradenitis suppurativa, which have traditionally been very difficult to treat.

In the past, people with extreme cases were unable to work or socialise and suffered potential side-effects from the broad immune suppression drugs used to treat the disease.

'Many sufferers had their lives ruined by these conditions .... a lot of people just gave up,' Dr Warren says. 'But in the past five years, we've welcomed new treatments for psoriasis, for example, that dramatically change the outlook and quality of life for patients.'

He says better understanding of underlying immune mechanisms and the disease process also meant dermatologists could treat earlier, improving the prognosis for some.

'Now, for the vast majority of people living with severe psoriasis, life can be made much more liveable – transformed by injectable monoclonal antibodies, targeting the interleukin-17 and interleukin-23 proteins. It's much more sustainable than the broad immune-suppressing treatments we've used in the past,' he says.

Monoclonal antibody self-injections have been added to the PBS for atopic dermatitis – the first of a new generation of treatments about to become available. Immune-based treatments are also being used with great success to manage advanced malignancies, especially metastatic melanoma, Dr Warren says.

In addition, oral treatments are becoming available for immune-mediated conditions such as alopecia areata. 'These are not yet on the PBS but I expect they will be shortly – it's a new exciting era, especially for those who have been suffering for so long,' he says.

Yet while these new treatments offer so much hope for patients, access to dermatology remains limited – especially for those in regional areas and in the public health system.

Public hospital dermatology services are limited to the RAH, Flinders Medical Centre and the WCH and Queen Elizabeth Hospital, with no public service in regional areas, nor at Lyell McEwin or elsewhere in northern Adelaide.

Dr Warren says the existing public services are predominantly staffed by visiting consultants and are severely under-resourced. Outpatient appointments are regularly double booked, leaving 7.5 minutes for each consultation, including for the most difficult cases, in at least one centre.

'Public hospitals should all have comprehensive dermatology services for inpatient care, specialty consultations, outpatient care and training of dermatologists, hospital staff and students,' Dr Warren says.

'The underfunding of public dermatology has resulted in unacceptable waiting lists and unsustainable pressure for staff. There is minimal research and inadequate time for administrative or audit activities.'

Given the need to triage patients into limited clinics, Dr Warren says general practitioners should expect to have referrals with insufficient information returned to them. While algorithmic computerised triage processes for specified conditions are being considered, they remain a 'pipe dream' as there are insufficient resources to progress the concept, he says.

Dr Warren says the situation is even more dire in rural and regional areas throughout Australia. In South Australia, there are no resident dermatologists outside Adelaide, and in the Northern Territory there is one resident specialist dermatologist.

'I'm currently working to try to provide a mechanism for an increase in visiting specialists to support our NT colleague as his burden is not sustainable,' Dr Warren says.

'There needs to be immediate action on ways to make rural and regional specialties, as well as general practice, viable and attractive. If that can't be done (we need) to assist and offer support for outreach – even outreach visits are generally seen as an altruistic service due to lack of financial or organisational support at state and federal levels.'

While the COVID experience with telehealth had shown some potential opportunities to improve dermatology triage with photographs ('store and forward'), this was not supported by Medicare rebates, he says.

'In general, the telehealth experience during COVID shows most dermatology care requires face-to-face detailed examination and direct consultations.

'Around Australia there is a maldistribution of specialists for which solutions are difficult to find. While there is significant unmet demand in urban areas, it's hard to imagine how we will get anyone to live in or serve needy rural areas in the long term without new incentives.'

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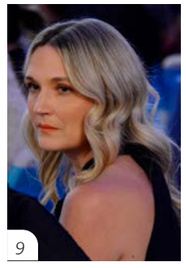
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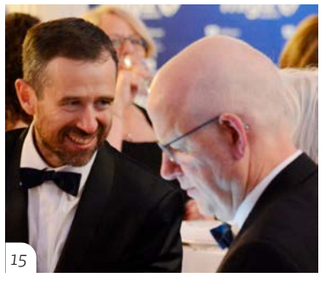
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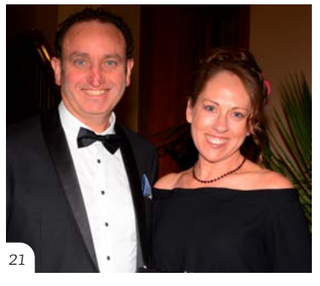
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More than 250 people attended the sold-out AMA(SA) Gala Dinner at the Adelaide Town Hall on 22 May 2021.

1. Mr Alex Hanin, Dr Evelyn Yap, Dr Sheldon Chong, Mrs Bernadette Chong, Dr Kien Ha, Mrs Ruby Ha, Mrs Feng Tam, Dr William Tam, Dr Jane Zhang, Dr Ted Mah
2. Assoc Prof Rosalie Grivell, Dr Jayanthi Jayakaran, Mr Emerson Krstic, Mr Sam Paull, Ms An Lam, Ms Christine Mausolf, Ms Jayda Jung, Ms Taylor Strube, Dr Liz Beare, Mr Midhun Kallumadickal, Ms Kiara Song and Mr Robin Lu
3. Dr Samantha Mead, Ms Lisa Hickey, Dr Penelope Batterham, Mrs Helen Hadjisavva, Ms Heang Lay
4. Dr Chris Moy, Mr Chris Picton, Dr Michelle Atchison, Dr John Williams, Dr William Tam
5. Mrs Christy Pirone, Mr Ralf Pirone, Ms Margaret Brown, Dr Christine Drummond, Mr Stuart Drummond
6. Mrs Jacqueline Genesin, Dr Linda Foreman, Dr Danny Byrne, Dr Kerry Hancock, Dr Paul Muffet
7. Mr Nicholas Robins, Ms Natasha Moy, Mr Tim Moy, Dr Monika Moy, Dr Chris Moy
8. Dr Barry Rowe, Dr Michelle Atchison
9. Dr Stephanie Clota
10. Mrs Feng Tam, Dr William Tam
11. Mrs Anna Pesce, Dr Andrew Pesce, Dr Fiona Reilly, Dr Stephen Parnis
12. Mr Chris Brougham, Ms Rosey Batt, Mrs Cathy Nelson, Dr John Nelson
13. Dr Thiru Govindan, Dr Jayanthi Jayakaran
14. Dr Shriram Nath, Mrs Lakshi Nath, Mrs Ganga Gamage, Dr Lalith Gamage
15. Dr Paul Muffet, Dr Richard Johns
16. Ms Rose Powell
17. Dr Annette Newson, Mrs Janette Harris, Dr Mark Harris
18. Dr Bridget Sawyer, Ms Catherine Waite, Dr Johanna Kilmartin
19. Dr Jane Ford, Professor Hubertus Jersmann, Dr Peter Ford
20. Dr Charlotte Huestis
21. Dr John Williams and Ms Nola Kennedy-Williams

There's an app for that

Medicine is increasingly using technological tools such as apps to monitor symptoms and share advice.

Parkinson's SA Executive Director Ms Olivia Nassari

'There's an app for that' is an aphorism of meme and legend. Often, it's reminding us that no one is indispensable. It's also reminding us though that technology is transforming lives, making simpler things that were difficult – even, or perhaps, especially, in health care.

Even before COVID-19 lockdowns had us searching for online workouts to replace the gym, Adelaide-based Kyla Istines and Tobi Pearce had taken the world by storm with their data-driven online fitness program, SWEAT, and the associated app – one of Apple's highest grossing apps.

And who hasn't heard of the many mindfulness apps, designed to help us keep calm and carry on, to sleep and to eat mindfully?

Wearable devices are increasingly being used for remote monitoring – for example, outpatient monitoring of vital signs. Over the past 15 years, wearable monitors with multiple sensors, intelligent processing, alarms to support medical decisions and interactions with the health provider have been developed.

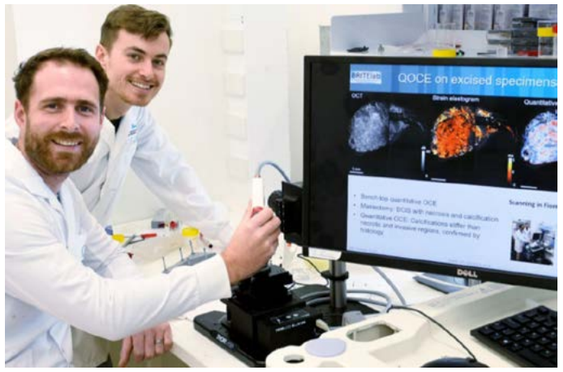
Apps and new wearable devices are also helping people with chronic diseases manage them more effectively. For example, those suffering from neurological diseases such as Parkinson's disease are finding technology can help balance treatment and its side-effects.

Young onset Parkinson's Exchange (YOP-X)

A new app and resource hub developed for people younger than 65 diagnosed with young onset Parkinson's is helping people identify and manage the condition.

The app - Young Onset Parkinson's Exchange (YOP-X) – provides information and tools to help people live better with young-onset Parkinson's and access the support they need through the National Disability Insurance Scheme (NDIS).

Executive Director of Parkinson's SA, Ms Olivia Nassaris, says the app provides tools with information about topics including negotiating flexible working arrangements with employers, managing relationships and sexual function, and



improving sleep patterns for people with young onset Parkinson's.

She says this is important because people living with young onset Parkinson's contend with debilitating motor impairment, as well as non-motor symptoms such as anxiety, depression, apathy and sleep disorders that can substantially compromise their quality of life.

'More than 20,000 Australians are living with young onset Parkinson's and the incidence has increased by 40 per cent over the past 10 years,' Ms Nassaris says.

Against this backdrop, YOP-X provides patients with easily accessible information, self-assessment and provides prompts and reminders to help people set goals and establish routines.

The app, free and downloadable via the App Store or Google, is based on six key pillars of young onset Parkinson's management, including mental health and emotional wellbeing; employment and legal issues; sex, relationships and intimacy; sleep, fatigue and maximising energy; exercise and nutrition; and changing your brain.

'It also includes the NDIS Wallet, an Australian first that provides an efficient way to consolidate everything the NDIS needs to know about someone living with young onset Parkinson's, to consider an NDIS application,' Ms Nassaris says.

'The wallet and accompanying YOP-X website provide healthcare professionals and NDIS-contracted providers with the knowledge they require to better meet the needs of their clients living with neurological degenerative conditions.'

For more information on the YOP-X project and to access tools and resources, www.youngonsetparkinsons.org.au

Personal kinetigraph (PKG) watch

Another wearable technology is helping people with Parkinson's disease monitor their symptoms, enabling more accurate treatment.

The kinetigraph or personal kinetigraph (PKG) watch provides a full clinical picture to the treating neurologist and provides alerts to the wearer to ensure medicines are taken as prescribed. It continuously records and stores data about symptoms such tremor, bradykinesia and dyskinesia (slow movements and rigidity). This enables the treating neurologist to adjust medication timing and dosage.

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The watch, developed by the Global Kinetics Corporation, provides patients with objective information about their symptoms, responds to the understanding that treatment requires self-reporting and this is often unreliable, even with validated assessments such as the Unified Parkinson's Disease Rating Scale (UPDRS). It is widely reported that patients tend to do better during clinical examinations than at home.

The PGK uses accelerometers to monitor movement and a proprietary mathematical algorithm to convert the raw movement data into a PKG report — a graphical illustration of the patient's movement that the clinician can analyse.

During an evaluation of the PKG with 63 people with Parkinson's, participants reported their own analysis of their symptoms and cross-checked this with the data provided by the watch – and found the watch to be considerably more accurate.

The study demonstrated the presence of symptoms not reported by patients in 35 per cent of the study cases. Among these symptoms, bradykinesia was the most common finding of the PKG not picked up by the patient (50 percent of cases), followed by dyskinesia (33 per cent). In contrast, 24 per cent of patients reported a symptom that did not appear in the PKG report.

The device identified individuals who could benefit from increases in levodopa doses or other treatments, including 47 per cent of those with bradykinesia and 44 per cent of those with dyskinesia.

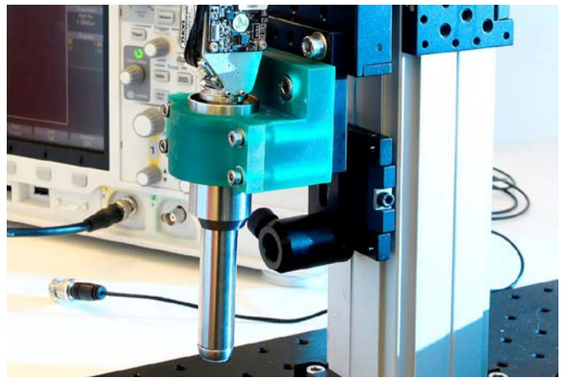
In total, the report provided insights used to change treatment plans in 79 per cent of participants, improved dialogue with the patient in 59 per cent of visits, improved the ability to measure treatment impact in 38 per cent of visits, and improved motor assessment in 33 per cent of visits.

When surveyed at the end of the study, 82 per cent of the participants agreed or strongly agreed that the PKG was easy to learn, easy to use, enabled them to confirm medication administration, and performed as expected. These patients said they would use the device again. In 39 per cent of responses, participants also reported a very valuable impact on their care.

OncoRes Medical

A new Australian imaging device has been designed to make real-time tumour margin assessments during breast cancer surgery to help surgeons more accurately identify and remove cancerous tissue.

The 'QME' imaging technology, being developed by Perth-based company



OncoRes Medical, has been shown to have 96 per cent accuracy on excised tissue and is being fast-tracked by the US Food and Drug Administration on the basis that it has potential to provide more effective treatment of life-threatening or irreversibly debilitating diseases.

The device is expected to dramatically improve the accuracy of surgery to remove tumour tissue and save patients from multiple surgeries which are common among breast cancer patients.

OncoRes Medical CEO, Dr Katharine Giles says the imaging system intensifies the surgeon's sense of touch, enabling real-time, high resolution intraoperative assessment of the surgical cavity.

'We know that facilitating detailed assessments in-cavity may improve surgical accuracy and support complete tumour removal, the first time. Breakthrough Device Designation from the FDA is a strong endorsement of our technology and its potential to change, even save, lives,' Dr Giles says.

Cancerous tissue is well known to vary in stiffness from healthy tissue. After the main specimen is excised during breast cancer surgery, the handheld QME probe is applied to regions of interest within the surgical cavity and generates micro-scale three-dimensional maps of the elastic (stiffness) properties of the scanned regions.

These micro-scale maps of tissue stiffness offer surgeons an optical imaging method for assessing breast tissue for the presence of microscopic or otherwise non-palpable cancerous tissue remaining inside the breast.

OncoRes Medical chief medical officer and surgeon Professor Christobel Saunders, oncology professor at the University of Western Australia, says that when it's approved for sale, OncoRes Medical's QME Imaging System will be important in identifying at a microscopic level whether a tumour had been entirely removed.

'One in five patients undergo repeat surgeries, which increases their risk of further complications such as infection,' Professor Saunders says. 'Many choose to have a mastectomy rather than risk a non-complete removal of cancerous tissue.'

About 20,000 Australians were diagnosed with breast cancer last year, with the disease accounting for 14 per cent of new cancer diagnosis and 6.3 per cent of cancer-related deaths, according to Cancer Australia.

Telehealth has role in future medicine

Patients' acceptance of telehealth is a major step in its permanent role in general practice.

A study that found patients with complex health issues were highly satisfied with general practice telehealth consultations during the COVID-19 pandemic in the first half of 2020 paves the way for further telehealth innovation, a Flinders University research team suggests.

The study[1] interviewed 30 patients – mainly older people with chronic health conditions, from nine general practices in metropolitan Adelaide, who had been identified by their regular doctors as being at high risk of poor health outcomes.

Head of General Practice in the College of Medicine and Public Health at Flinders University, Professor Richard Reed, says that of the 30 participants, 25 had used telehealth consultations at least once and had found them an important way of maintaining continuity of care during the peak of COVID-19 anxiety in May-June 2020.

'If you go back in a time machine to May and June last year, it was a period of high concern with many people being fearful of catching COVID-19,' Prof Reed says. 'It meant that people in this group were anxious leaving the house, and the fact they had access so quickly to telehealth and the level of satisfaction was so high was a pleasant surprise.

'It proved to be a very rapid transition for general practice and yet the level of satisfaction of patients was quite high.'

The survey showed that people liked that telehealth saved time and was convenient, but they also liked having the option to use face-to-face consultations – especially if they needed a physical examination or had something they found difficult to speak about over the phone.

Participants emphasised the importance of having a good relationship with their regular doctor for telehealth consultations to be effective. The most common reasons for telehealth consultations were for prescription renewal, discussing test results, and follow-ups.

However, participants also identified challenges with using telehealth services, including difficulties in expressing themselves and in accessing physical exams.

Of the more than 50 million telehealth consultations that had occurred since telehealth consults were added to the Medicare Benefits Schedule last year, telehealth had been broadly supported by doctors and patients, Prof Reed says.

Most telehealth consultations were provided by GPs from their practice, given the privacy challenges of remote work, access to software and the additional administrative burden of telehealth consults. Anecdotally, some doctors with health conditions that increased their risk of infection particularly valued the opportunity for remote consultations.

Prof Reed says the extensive adoption of telehealth points to the need for a policy model that supports its integration into general practice.

'People have tended to think of telehealth as lesser option to face-to face care, but I think that integrating telehealth into routine general practice is important because it improves accessibility,' he says. 'It could enhance clinical care by enabling general practice to better monitor their patients' health in their homes.

'Going forward, now that we've had this change in the funding methodology, the government has indicated that it wants to support general practices to provide telehealth options that promote improved access to general practice care.'

The model should not be 'one size fits all', he says. A person with a physical disability might find telehealth particularly useful while someone with easy access to a clinic might prefer to drop in and see a doctor face-to-face.

Early policy challenges include discouraging the use of pop-up telehealth facilities in favour of supporting continuity of care through a patient's usual general practitioner – an issue the AMA worked hard to resolve with the government last year.

'The real opportunity is telehealth as a broader service than merely telephone consultation,' Prof Reed predicts. 'There's also remote monitoring of illnesses; increasingly we have devices that can be used to remotely measure people's health status, and this information can be provided to general practices – for example, for people who have had heart failure.

'We need to look at what's the best way to use telehealth now that we have, we hope, a funding stream that will continue after the end of the year. In the future, telehealth in Australia is likely to have a stronger place in primary healthcare policy and practice and an increased acceptance among patients.'

[1] S. Javanparast, L. Roeger, Y. Kwok and R. Reed – 'The experience of Australian general practice patients at high risk of poor health outcomes with telehealth during the COVID-19 pandemic: a qualitative study' BMC Family Practice (doi.org/10.1186/s12875-021-01408-w).

Digital delivery

Global Centre for Modern Ageing research shows the dramatically increased availability of digital health services has many benefits for older Australians.

Global Centre for Modern Ageing CEO Julianne Parkinson

In partnership with Google Chrome Enterprise, the Global Centre for Modern Ageing (GCMA) research team undertook qualitative research into digital health in the home between March and May this year. *Inspiring new models of care: Digital health in the Home* investigated the challenges and opportunities facing the Australian healthcare industry in adopting rapidly changing digital technologies and delivery methods.

GCMA CEO Julianne Parkinson says the research was conducted to obtain a clear understanding of how older people view health technology becoming integrated into their homes, and help build a bridge between people's needs and current market realities.

'We spoke with clinicians, aged care staff and community members,' Ms Parkinson says. 'Our findings demonstrate that a coordinated effort is required to reskill industry, validate and shed light upon the most suitable technology, and to design models of care that will not compromise on quality care provision.

'Improvement in the quality of life of the older person must remain the number one priority.'

The GCMA conducts research into the business of ageing. By partnering with businesses and government across the built environment, workforce planning, finance and age-tech to discover futures for products and services that will contribute to individuals' wellbeing, the GCMA tests and validates these initiatives through pilots both onsite at the Living Lab at Tonsley in southern Adelaide, and in the community.

The GCMA specialises in co-designing solutions to deliver better outcomes for industry, government, and families while supporting Australians as they age.

'We believe digital health is central to enabling people to age in place,' Ms Parkinson says. 'Breaking down barriers through more considered technology design is crucial to improving quality of life and care of people as they age.

'Including end users and health care workers in health technology design will improve usability and workflow integration. Providing central and independent information and industry skills development are some of the clearest steps forward.'

GCMA Strategic Adviser Professor Justin Beilby says the report coincided with more medical practitioners using telehealth to deliver day-to-day care.

'It is clear that telehealth as part of digital suite of services delivered at home has a role in contributing to a person's overall care,' Prof Beilby says. 'But we clinicians should not allow this decrease in face-to-face contact diminish our outstanding care.'

PRIORITY AREAS FOR DIGITALLY ENABLED HEALTHCARE

	Community members	Aged care providers	Clinicians
Increased accessibility of care	!		
Improved safety	!	!	
Better Health outcomes	!	!	!
Enabling independence	!	!	
Workflow efficiencies		!	!
More proactive, preventative, and predictive healthcare	!	!	!
Greater peace of mind for users and family	!		

Research data was distilled into five key thematics, highlighting current views, ideas and hopes for digital technology in Australia:

- identifying priority areas for more digitally-enabled healthcare provision
- reasons quality of care must remain top priority
- the importance of communicating the benefits of technology for healthcare and ageing well
- the definition of digital health
- barriers to adoption as determined by target audiences.

Priority areas for more digitally enabled healthcare

To understand current views as to priority areas and goals for more digitally-enabled home healthcare provision for older Australians, we spoke to older Australians, aged care providers, and clinicians.

Community members identified as their top priorities:

- increased accessibility of care
- improved safety
- better health outcomes
- enabling more independence
- more proactive, preventative, and predictive healthcare
- greater peace of mind for users and their families.

Aged care providers nominated their priorities as:

- improved safety
- better health outcomes
- enabling more independence
- workflow efficiencies
- more proactive, preventative, and predictive healthcare.

Ms Parkinson says the research showed that better health outcomes and more proactive, preventative, and predictive healthcare ranked highly for all respondents.

Quality of care must remain the top priority

The most important factor for respondents was the quality of care, and that it remain the top priority.

Findings showed that for respondents to embrace widespread uptake of health technologies in their homes, the technologies must support quality of life and care, enhancing and supplementing existing services.

Respondents emphasised that technology should not be designed or implemented to replace face-to-face provision of care.

The importance of communicating the benefits of technology for healthcare and ageing well

The research found that the benefits health-related technology can provide to older Australians living at home are often not well communicated, and that emphasising the benefits to all stakeholders will improve uptake.

For instance, communicating the preventative and early detection benefits afforded through health technologies may shift community perceptions from the mindset that technology is used only to manage poor health or illness.

For professional cohorts, highlighting the potential improvements in providing care and workflow efficiencies could improve buy-in.

Definining digital health

A definition of digital health helps avoid confusion, Ms Parkinson says. The GCMA has defined digital health as 'an ecosystem designed to support and improve the health and wellbeing of older Australians, while making it easier for aged care providers to offer in-home support, and enabling clinicians to look after patients' health, face-to-face, and when they are at home'.

Looking to the future, she says, the digital health ecosystem will include evidence-based innovations, products, care pathways, collaborations, partnerships and programs with the following objectives:

- reduce inefficiencies
- improve access
- reduce costs
- increase quality
- make medicine more personalised, preventative, and predictive.

Barriers to adoption

In another key research outcome, clinicians and aged care providers professionals identified they barriers they face in increasing the adoption of digital technologies by their patients and clients.

BARRIERS TO ADOPTION

	Aged care	Local Clinicians	Hospital Clinicians
Poor digital Literacy among staff	X	X	X
A lack of data Interoperability	X	X	X
A lack of trust in the technology (a lack of validation)	X	X	X
Knowledge of available technology	X	X	X
Legacy IT Systems	X	X	X
Funding, ROI, and reimbursement	X	X	
Lack of, or unclear governance standards	X	X	
Poor workflow integration	X	X	
Insufficient or lack of training	X	X	
Data management & response (e.g., security, liability and procedures)	X	X	
Funding: Access to hardware	X		X
Workplace culture	X		X
Technical limitations (e.g. wifi capabilities)	X		
Misconceptions of older people & tech use	X	X	

For more information or to receive a copy of the report, visit www.gcma.net.au

Love in the time of COVID

The pandemic's effects on STI epidemics remain uncertain, write Tom Rees and Jana Sisnowski of SA Health's Communicable Disease Control Branch.

The downstream effects of the COVID-19 pandemic on the health system and on broader population health and wellbeing remain uncertain. The identification of and response to these impacts will feature heavily in health-system planning over the coming years.

In March 2020, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) noted that 'the novel coronavirus (SARS-CoV-2) poses unprecedented and serious challenges to the delivery of health services to people affected by blood borne viruses (BBV) and sexually transmissible infections (STI)'.[i]

One year later, routinely collected notification and testing data provide an opportunity to examine the implications of the COVID-19 pandemic for STI epidemiology in South Australia (SA), and the strategic response to these infections in 2021 and beyond.

PUBLIC HEALTH SIGNIFICANCE OF STI

STI are associated with a range of sequelae including infertility, cancer, adverse pregnancy outcomes, pelvic inflammatory disease, poor mental health, and increased risk of acquiring HIV.[ii]

The current multi-jurisdictional outbreak of infectious syphilis affecting some Aboriginal and Torres Strait Islander communities is of particular concern due to rising incidence among women of reproductive age and the significant risk of infant morbidity and mortality associated with congenital syphilis. In 2017, the first notification of congenital syphilis in 18 years was recorded in South Australia. In 2020, eight cases of infectious syphilis in pregnant women (five of whom identified as Aboriginal) and two cases of congenital syphilis in Aboriginal infants were notified.[iii]

IMPACT OF COVID-19 ON STI NOTIFICATIONS

The COVID-19 pandemic was associated with a reduction in the number of notified cases of chlamydia (-12.8 per cent) and gonorrhoea (-21.2 per cent) in South Australia in 2020 relative to 2019 (Figure 1).[iii]

This contrasts with trends over the decade to 2019. Increases in the notification rate for chlamydia, gonorrhoea, and infectious syphilis were observed in the state and nationally over this period. For gonorrhoea and syphilis, the notification rate more than doubled, outpacing[1] increases in the level of testing over the same period, suggesting increases in transmission.[iii, iv, v]

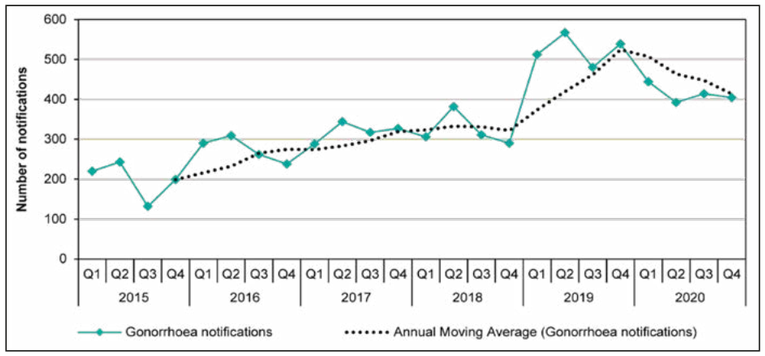


Figure 1: Gonorrhoea notifications, by quarter and year of notification, South Australia, Jan 2015 to Dec 2020

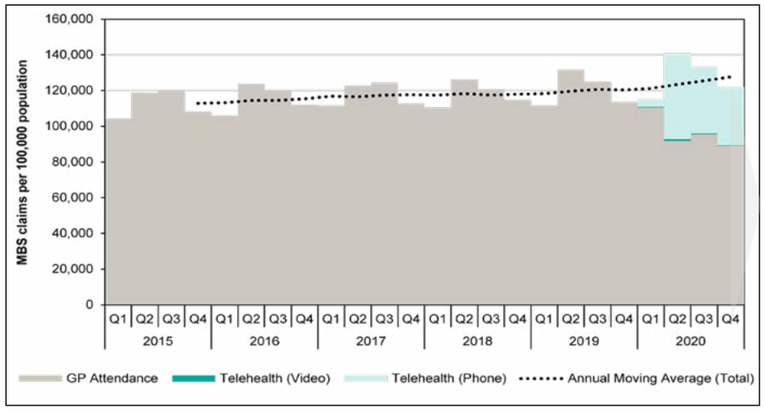


Figure 2: Claims per 100,000 population for MBS items related to standard GP attendances (face-to-face) and equivalent telehealth MBS items, South Australia, Jan 2015 to Dec 2020v

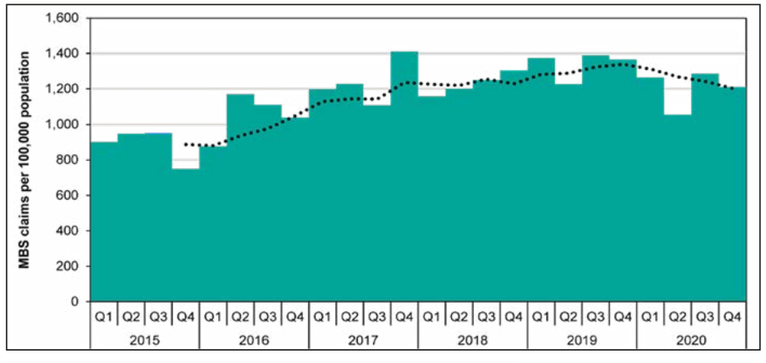


Figure 3: Claims per 100,000 population for MBS items related to chlamydia/ gonorrhoea testing, South Australia, Jan 2015 to Dec 2020

It is reasonable to hypothesise that the reduction in STI notifications in 2020 may be partly attributed to a true reduction in incidence due to factors such as suspension of international travel and behavioural changes during heightened domestic COVID-19 restrictions.[vi] However, it should be noted that COVID-19 'lockdowns' in South Australia have been relatively limited in both duration and intensity.

Furthermore, while STI transmission dynamics are multi-factorial, research suggests accessibility of health services is the most powerful predictor of STI prevalence, and that high testing coverage, partner notification and rapid treatment initiation are critical to reducing infection duration, suppressing transmission and controlling STI such as HIV, gonorrhoea and syphilis.[vii, viii]

IMPACT OF COVID-19 ON ACCESS TO PRIMARY CARE

Historically, general practitioners (GP) have accounted for 65 to 70 per cent of notified chlamydia and gonorrhoea infections each year in South Australia, highlighting the critical role of primary care providers in controlling and minimising the public health impact of these and other STI.[iii]

From March 2020, telehealth Medicare Benefits Schedule (MBS) items were made available to support the continued provision of health services, while reducing the risk of community transmission of SARS-CoV-2.[xi]

In South Australia, MBS data suggest that 24.2 per cent of all GP standard attendances in 2020 were conducted using telehealth. Furthermore, the rate of MBS claims for all general practice level A-D consultations increased by 6.1 per cent from 2019 to 2020, highlighting the importance of telehealth in mitigating the impact of COVID-19 on access to primary care (Figure 2).[v]

In July 2020, the Australian government announced reforms to telehealth arrangements requiring patients to have seen the same practitioner (or a doctor at the same practice) for a face-to-face service during the previous 12 months to access these items. These changes aimed to promote care continuity.[ix]

Service providers involved in STI and BBV control have raised concerns that these reforms create barriers to healthcare access for some members of the community, including people without a regular GP and people who attend a different provider for sexual health matters as the need arises (which is not uncommon). As such, the reforms may delay access to sexual and reproductive health services such as HIV pre- and post-exposure prophylaxis (PrEP and PEP), STI and BBV testing, contraceptive and pregnancy options advice.[x]

IMPACT OF COVID-19 ON STI TESTING

Of concern, available data suggest that STI testing rates declined in 2020 and are yet to rebound to the pre-pandemic trendline, despite the success of South Australia's response to COVID-19 and the relatively limited duration and severity of COVID-19 restrictions in the state.

There was a 10.1 per cent reduction in the rate of MBS claims for chlamydia/ gonorrhoea testing in 2020 relative to 2019.

This contrasts with trends over the preceding decade. Chlamydia/gonorrhoea testing rates increased during this period, likely reflective of both increasing incidence of these infections and of efforts to improve access to sexual health services (Figure 3).[v]

Similar trends have been observed in specialist sexual health services in this state and Victoria. Sentinel data from these services indicate large and sustained reductions in asymptomatic screening for STI in 2020.These changes were attributed to factors including cessation of walk-in services and prioritisation of symptomatic STI testing and HIV PrEP patients within the context of constraints on clinic capacity.[xi, vi]

Implications for STI epidemic control

With the COVID-19 vaccine roll-out and the potential for international travel in 2022, factors which drove growth in STI rates before the pandemic are likely to return. Before this occurs, Australia has a window of opportunity to regain control of current STI epidemics, and minimise the downstream health, social and economic impacts of these infections.

In the context of long-standing challenges to meeting state-wide demand for sexual health services while addressing the evolving impacts of the pandemic on health service delivery models, there is a critical need to diversify and broaden the geographic coverage of services providing sexual health care.

All clinicians (particularly those involved in antenatal care given the significant impacts of untreated infections during pregnancy) are urged to familiarise themselves with updates to STI and BBV clinical guidelines (including the SA Perinatal Practice Guidelines), and to consider opportunities to increase guideline-based screening for STI and BBV.

Further information on STI and BBV testing and treatment is available from the National STI Guidelines (www.sti.guidelines.org.au), ASHM (testingportal.ashm.org.au/) and SA Health (bit.ly/3onTWSR).

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ACCOLADES

Recognition for rural doctors

South Australia's country doctors who together have served rural communities for more than 665 years were honoured at the Rural Doctors Workforce Agency (RDWA) annual Rural GP Conference.

Nineteen GPs who have served their rural communities for at least 35 years each were recognised for their outstanding contribution to the health of people living in rural and remote South Australia.

The South Australian Governor, His Excellency the Honourable Hieu Van Le, and Health and Wellbeing Minister Stephen Wade watched as 35-year long service medals were presented by National Rural Health Commissioner Professor Ruth Stewart and RDWA Chair Dr Michael Beckoff.

RDWA CEO Lyn Poole congratulated and thanked each and every one of our rural GPs for their contribution to the health and wellbeing of their local communities.

Top (from left): Dr David Senior, Robe; Dr Graham Hughes, Mount Barker; Dr Allison Ramsey, Mount Barker; Dr Stephen Holmes, Clare; Dr Geoffrey Arthurson, Nuriootpa; Dr Kevin McEntee, Mount Gambier

Middle (from left): Dr Diana Cross, Mount Gambier; Dr Hayden Baillie, Port Lincoln (retired January 2021); Dr Susan Baillie, Port Lincoln (retired January 2021); Dr Peter Michelmore, Strathalbyn; Dr David Butler, Murray Bridge; Dr Paul Smith, Renmark

Bottom (from left): Dr Clive Fowler, Victor Harbor; Dr Christopher Muecke, Renmark; Dr Adrian Griscti, Angaston; Dr Colin Ingham, Victor Harbor; Dr Helen Robertson, Laura; Dr Michael Gregg, Kadina

NEWS

A leg up for doctors' health

AMA(SA) Council representatives Dr Chris Moy, Dr Danny Byrne, Dr Penny Need, President Dr Michelle Atchison and CEO Dr Samantha Mead

More than 170 people gathered at the 2021 #CrazySocksfor Docs Breakfast to recognise and reinforce the importance of doctors looking after their own health.

#CrazySocksforDocs highlights the mental health and wellbeing challenges experienced by doctors and makes it OK to talk about them. In only four years, it has grown from an idea to an annual event on the first Friday in June that reinforces the fact that doctors are people, and so can experience the mental health issues - anxiety, depression, burnout, fear, anger and more – that can by symptoms of mental health conditions or exacerbated by personal, workplace or other stressors.

Doctors' Health SA's Dr Roger Sexton talking to MC Paul Kitching during the #CrazySocksforDocs Breakfast panel discussion

Photos courtesy of SASMOA/Doctors' Health SA

Doctors' Health SA (DHSA) began supporting Crazy Socks in 2019, and with the South Australian Salaried Medical Officers Association (SASMOA) organised the 2021 #CrazySocksforDocs Breakfast at the Adelaide Convention Centre on 4 June. Fundraising will support the CrazySocks4Docs Trust Foundation.

DHSA medical director Dr Roger Sexton says the high-pressure nature of their jobs and some of the circumstances doctors are exposed to can leave doctors vulnerable. COVID has only brought that fact into the spotlight even more, he says, highlighting statistics demonstrating that doctors have a high suicide rate compared to most other professions.

Victorian cardiologist Dr Geoff Toogood, who created Crazy Socks for Docs, spoke via video link to the Crazy Socks Breakfast audience, which included Federal Shadow Minister for Health and Ageing Mark Butler, South Australia's Health and Wellbeing Minister Stephen Wade and Shadow Minister Chris Picton, and Dr Caroline Dingle, Mentally Healthy Workplace Consultant with the Office of the Commissioner for Public Sector Employment.

DHSA will be providing a report on the ideas shared from the panel and special guest (national) Deputy Chief Medical Officer Professor Michael Kidd, who in his presentation strongly advocated that all doctors must have their own GPs.

Dr Toogood's campaign began in 2017 when, after he wore odd socks to work one day, he noticed people talking behind his back and questioning his mental health. The reality was that his new puppy had been eating his socks, but he was struck by the stigma and discrimination still associated with mental health and wellbeing.

His initiative – now a global movement – calls upon people everywhere to wear fun socks on the first Friday in June, to raise awareness and normalise the mental health conversation.

'Thank you to the Doctors' Health SA service for the partnership with #CrazySocks4Docs to raise awareness and to attack particular problems in medicine - that being stigma, that being having a safe place to talk about your mental health both within an organisation and when you seek help,' Dr Toogood said.

'We are all about tangible projects, with the funding raised to support doctors on the ground.'

'CrazySocks is about driving change from the ground up, and the power within the profession to help itself,' Dr Sexton said.

SASMOA president Dr Laura Willington says work-life balance is critically important for medical professionals of all ages. 'Healthier, rested, non-fatigued doctors who can have balanced lives outside of work equals better decisions and healthier patients,' she said.

AMA(SA) Council and staff also raised awareness of #Crazy Socks through social media. Read more about the global campaign at www.crazysocks4docs.com.au

MC Paul Kitching interviewing Australian Deputy Chief Medical Officer Professor Michael Kidd

Diamonds emerge from COVID-19 pressure

The postponement of university graduation ceremonies and the presentation of AMA(SA) Student Medals was among many COVID-related influences on the 2020 academic year.

The AMA(SA) Student Medal acknowledges academic excellence and community contribution.

Each year medals are awarded to graduates of both the Flinders and University of Adelaide medical schools who have achieved academic excellence and made a contribution to the community.

It's always a difficult choice, as the talent is prodigious. Last year the choice was more difficult than ever – so much so that the AMA(SA) medal was awarded to two Flinders graduates as well as a University of Adelaide graduate.

As the outgoing AMA(SA) President Dr Chris Moy told graduates at the delayed University of Adelaide ceremony last month, pressure produces diamonds. The representatives of their respective medical school societies played integral roles in negotiating with the universities over the COVID impact on students and in keeping students connected during a disrupted academic year.

To have had one winner of the calibre of the two Flinders graduates who share the honour of the 2020 AMA(SA) student medal would be remarkable, Dr Moy said – but to have two was extraordinary.

Flinders Medical School joint winner **Matilda Smale** was recognised for her strong commitment to the Flinders Medical Student Society. She was described as an outstanding member of the Class of 2020 going 'above and beyond in every aspect of the degree both academically and in contributions to the university community – in medical school events and tireless support and reassurance to peers'. Her resume includes numerous publications, policy writing, research, and academic achievement; she was a finalist for the Staff Prize in Medicine in 2020 and received the Flinders University Chancellor's Letter of Commendation in 2019. As well as serving on the AMA(SA) Council and Doctors in Training committee, Dr Smale worked as a Rural Student representative, publications director and student mentor, supporting students and encouraging rural students to study medicine.

The other Flinders University winner, **Liam Ramsey**, was acknowledged as a deep thinker and a tireless advocate for students and peers, standing with the vulnerable and advocating to overcome social inequity. Despite making himself available for staff and students at all hours of the day and night during the pandemic, he achieved outstanding academic results, and engaged in extensive research and co-curricular activities.

In addition to winning academic excellence awards in 2016 and 2017, Dr Ramsey was a student researcher at SAHMRI and a tutor. He co-authored a publication in the Medical Journal of Australia on clinical placements for medical students during COVID-19, presented at the HIV & AIDS + Sexual Heath 2020 Virtual Conference, and won a full scholarship to the 2019 RANZCP Psychiatry Congress. His nominator noted that he 'has demonstrated in words and actions his belief that as doctors we have a duty to provide safe and equitable healthcare to all people'.

Dr Chris Moy with University of Adelaide AMA(SA) Student Medal winner Jade Pisaniello and Assoc Prof Jo Thomas

Dr Moy with Liam Ramsey and Matilda Smale at the Flinders University graduation ceremony

Dr Matilda Smale

Since completing medical school at Flinders University in 2020 I have commenced my internship at SALHN. My first two terms have been at Flinders Medical Centre in general and gastrointestinal surgery and medical nights cover, and I will be commencing obstetrics and gynaecology in a few weeks. I have also been fortunate to have opportunities to be involved within the SALHN Junior Medical Advisory Committee and the AMA(SA) Doctors in Training committee. I have had an incredible start to internship, with supportive senior colleagues and a friendly workplace making work a positive experience. Each day brings a new challenge and lesson to learn, and I am thankful to SALHN for continuing to create the environment it does for its interns.

It was an honour to win the medal alongside one of my peers, Liam, in 2020 – it felt rewarding to have our hard work throughout 2020 be recognised by individuals and an organisation I have a lot of respect for.

The best thing about internship since winning the medal has been the people/friendships you make along the way. It makes the hospital a friendly environment when you turn up to work and have lots of friendly faces to say hello to. Every day is a challenge, but my most challenging thing so far has been doing medical nights cover in term 2 of internship – it has been a huge step up.

The University of Adelaide winner of the AMA(SA) Student Medal, **Jade Pisaniello**, demonstrated great leadership as an advocate for students in a time of significant challenge.

Dr Moy said that from the beginning of her time at the university, she was committed to excelling at her studies and was a ClinPrac and Peer2Peer tutor, flinging herself into every aspect of the degree, from AMSA to the MedRevue. She was a strong advocate for medical students at the University of Adelaide, representing AMSA interstate and lobbying politicians over key issues, such as the potential oversupply of medical graduates. She worked equally hard to build a sense of community among students with social activities and helped to create the Professor Peter Devitt Surgical Excellence Award.

Dr Jade Pisaniello

It was a privilege to have been selected as the University of Adelaide's recipient of the AMA Medal by AMA(SA). After the graduation and declaration ceremonies, both of which occurred on the same day, I emerged from Bonython Hall, surrounded by the smiling faces of my cohort, my very good friends, who were now newly minted doctors. In this moment, I found myself reflecting on the significance of time and how quickly our six years at medical school passed by; six years of unforgettable memories, friendships forged, mistakes, triumphs and everything in-between.

As a graduate, I have walked away not only as a doctor but with a host of special memories created alongside exceptional friends whom I am sure will remain by my side for the rest of my life. A culture of camaraderie is a core value of the medical profession and is something the AMA(SA) has encouraged us to develop (from as early as orientation week of first year medicine!). I am proud of the culture of collegiality the Class of 2020 perpetuated throughout our years at medical school and it will carry with us as we continue into our careers. Although our paths are already beginning to diverge, it was wonderful to be reunited as a cohort to officially celebrate our graduation. I hope we can always reflect and find comfort in the bond we developed together throughout our studies over more than half a decade at the University of Adelaide.

It seems like just yesterday I was emailed by the university with an offer to study medicine and now I am working at the new RAH as an intern. The years I spent at medical school will be cherished and I think I will always look back on them as the best years of my life. It was an honour to have been elected as President of the Adelaide Medical Students' Society in sixth year and work with AMA(SA) as we guided students through medical school in the face of a pandemic. To have had my contributions recognised by Dr Chris Moy and the AMA(SA) staff is an immense honour for which I will be forever grateful.

Dr Liam Ramsey

I am a current RAH Intern, wannabe DJ and amateur vegan chef. I am also the former president of the Flinders Medical Student Society (FMSS) and was lucky enough to have been awarded the AMA (SA) Student Medal for 2020 by Dr Chris Moy.

It was one of the highlights of my medical degree and incredibly validating for the large amount of work Matilda Smale and I put into advocating for students in 2020. It's crucial to recognise work that students do in the leadership and advocacy space because it legitimises the sacrifices made and encourages other students to step up and become active members of our community. The medal is also another connection between medical students and the AMA. Having the AMA recognise the student contribution is a way to continue transitioning students into leadership roles as junior doctors and keep them excited and interesting in the AMA's many advocacy channels.

Following my departure from Flinders, I have been working at the RAH as an intern before doing a stint at the WCH in paediatrics. I am confidently taking a step back from leadership roles this year to focus on learning on the job and on myself. Internship has been an overwhelmingly positive experience, despite the insurmountable pile of discharge summaries, 'pager post-traumatic stress disorder' and sleep deprivation. Feeling integral to the team dynamics, having meaningful interactions with patients and mentoring students coming through makes the profession incredibly rewarding and I am genuinely excited for what the future holds as a RMO and beyond.

Many (different) parts to make a whole

SAM PAULL
STUDENT NEWS:
FLINDERS UNIVERSITY

One of the advantages of studying medicine in a post-graduate course is the diversity of the 'pre-medicine' experiences of the cohort. Some students have backgrounds in health-related fields such as physiotherapy, nursing or paramedicine, while others have degrees in fields as broad as journalism, graphic design or commerce. One of my peers has been a world-class Muay Thai fighter; another worked as a DJ in a club in Portugal and as a snowboarding instructor in Canada. Each of the students brings something unique to the cohort, and we all benefit from leveraging their expertise in enriching our own learning.

My background is in engineering. I first studied a mechatronics degree, a mixture of mechanical and electrical engineering, and followed that with a career in satellite communications for almost a decade. When I started at Flinders, I was terrified that my lack of health-related background would put me at a large disadvantage that I would struggle to overcome. I thought that engineering and medicine were so dissimilar that I would effectively be starting from square one, with nothing much to show for my years of study and work experience. Luckily for me, I couldn't have been more wrong. The skills that I learnt in engineering such as problem solving, critical thinking and communication are all equally important in medicine, and they gave me a good foundation on which to commence my studies in a new profession.

Just as my experiences have aided me in my medical studies, I feel that engineering thinking could be used more broadly in medicine to help tackle some of the complex problems that exist within the health system. When designing and integrating a new complex product, engineers will typically look to the concept of 'systems engineering', where the goal is to create a combination of components working in synergy to collectively perform a function. A hospital is a great example of a complex system, with a variety of different components that must work together synergistically to provide care for our patients. However, my experience with hospitals is that they are often quite piecemeal in their structure, with lots of different siloed teams and technologies, and could benefit from a systems approach to design. This is not an original idea on my behalf; in 2016, a Johns Hopkins medicine team worked together with their Applied Physics Laboratory engineers (famous for their work with the US Department of Defence) to attempt to improve patient safety and quality of care in their intensive care unit (ICU). The initiative proved successful, significantly reducing the functional decline in mobility of ICU patients. This demonstrates how it is possible to use ideas and concepts from outside medicine to improve the health system.

In the same way that medicine has adapted to an interprofessional and multidisciplinary team environment to improve patient outcomes, I think that broadening our horizons to take lessons from seemingly dissimilar fields could be a great way forward. I believe that the graduates of Flinders, with their diverse backgrounds and experiences, have a unique opportunity to make an impact in their future careers and I look forward to seeing their achievements and contributions to medicine.

MD degree creates opportunities

PATRICK KENNEWELL
STUDENT NEWS:
ADELAIDE UNIVERSITY

The first cohort of Doctor of Medicine students (MD) will launch their medical studies next year, signalling a major change at the University of Adelaide Medical School. Students are optimistic about the recent appointment of a new Director of Medical Education, Dr Benedict Canny, to oversee the ongoing delivery of the MBBS program and the inception of the MD. The Adelaide Medical Students' Society (AMSS) has embarked on a productive relationship with Dr Canny, a previous AMSS secretary, and we are looking forward to continuing to work closely with him.

It has been a very busy few months on the advocacy front for our AMSS Team Education, which has put together a fantastic submission to the Australian Medical Council. The team is working closely with faculty to ensure we retain the great aspects of our existing program while using the opportunity of the new MD to provide exciting and improved teaching opportunities.

We have continued a great working relationship with the medical school through regular meetings with the interim Dean Dr Martin Bruening and Years 1-3 Coordinator Dr Andrea Dillon this year, including gaining support for students to attend the School Strike for Climate representing Doctors for the Environment, recognising the health issues that result from damage to the natural environment.

We were pleased to obtain continuing support from the medical school to allow all students a Friday afternoon off to attend our annual football carnival. We were fortunate this year to be able to hold MedFooty with suspense around its long-awaited return, following washouts in 2018 and 2019 and a cancellation last year because of COVID. It is a significant day, recognising the importance of support and camaraderie among the student cohort. We saw some fantastic competition across all year levels and were proud to be raising money for Mental Health Australia on the day. In the women's tournament, the first years emerged victorious, and in the men's the combined clinical-year men's team defeated a formidable third-year team by two goals with minimal assistance from the umpires.

Following MedFooty we are excited to be a part of CrazySocks4Docs, which promotes the normalising of discussions around mental health within medicine and within the medical school to ensure we are well supported on campus and at placement.

Further afield, final-year students are making the most of being able to undertake rural and interstate elective placements this year. For me, this has allowed me to go to Alice Springs, where I'm currently writing this article. This elective has opened my eyes to the challenges faced by rural and remote Australians in accessing healthcare that we can take for granted living and studying in a city. I think a lot of us have found fantastic elective experiences within Australia that we may not have considered if, as is normally the case, alluring international electives were available to us.

Having just visited the grave of Royal Flying Doctor Service pioneer John Flynn, it has been disappointing to see changes that have resulted from the latest federal budget with the cancellation of the John Flynn Placement Program. This program has given many students the opportunity to experience the challenging and rewarding aspects of rural general practice across Australia. The funding from this program has been redirected towards rural placements for junior doctors. This is an equally important cause, but it is a shame that support for it had to come at the expense of the existing student placement program.

Looking forward to the next few months, we are proud to have students working so hard to put together the Australian Medical Students Associations National Convention at the Adelaide Convention Centre from 2 to 4 July. The convention features an amazing social and academic program with Professor Nicola Spurrier, Dr Yumiko Kadota and Dr Dinesh Palipana and many more.

Dr Nimit Singhal
Ordinary Member
AMA(SA) Council

AMA(SA) Council Meeting May 2021

The AMA(SA) Council met on 6 May 2021 for an abridged Council meeting, due to the Annual General Meeting (AGM) that followed the general council meeting. Dr Michelle Atkinson chaired the meeting.

Then-AMA(SA) President Dr Chris Moy updated the council regarding the COVID-19 vaccine roll-out, of which there has not been a huge uptake for various reasons, including supply of the vaccines and concerns about side effects.

One of the issues that has been raised is indemnity for health care professionals who are giving the vaccines in good faith. Retrospective indemnity for vaccination for health care providers will be a step in the right direction and has been accepted in principle.

Council was unanimous in supporting COVID vaccination for all, as that has shown to reduce severity of illness and prevent transmission. The role of general practitioner (GP) colleagues was highlighted; it was noted that as of the date of the meeting, GPs had vaccinated twice the number of people compared to vaccination hubs.

Discussion turned to the AMA(SA) Gala dinner in late May, and it was announced that attendees would be asked to consider donating to a specified fund, recommended by Indian members and colleagues, for COVID relief in India.

Supporting rural GPs was the next point of discussion. Fee-for-service negotiations are ongoing. There is a significant dearth of certain specialities in rural practice like geriatrics, paediatrics, rheumatology, palliative care and psychiatry. Allied services such as psychology are lacking as well. Rural generalists need support from SA Health.

Council approved the draft submission relating to the South Australian Government's Budget announcement in June, and the auditor's report for the past financial year.

The AMA(SA) Doctors in Training continue to work for climate change, with the Committee presenting its brief to the Council.

It has been a busy and difficult year for AMA(SA) with the COVID health crisis and disruption of the physical space at AMA House due to fire and water damage and ongoing renovations. The work at AMA House is expected to be finished by the end of the 2020-21 financial year.

AMA SOUTH AUSTRALIA

AMA(SA) Council Meeting June 2021

At its June meeting, the first after the Annual General Meeting in May, Council welcomed new AMA council members and a had a group photograph taken. The photo and detail about our new Councillors can be seen on page 7.

In relation to COVID-19 we discussed the urgent need for specifically designed quarantine facilities, ready PPE availability, vaccine hesitancy issues, aged care facility vaccination roll-out, rapid testing availability for COVID-19 and adequate ventilation facilities beyond the nRAH.

Ongoing discussions were had in relation to concerns about the capacity within the new proposed Women's and Children's hospital. AMA(SA) will be attending a meeting shortly with the Department for Health and Wellbeing, when modelling and plans for the new WCH will be discussed.

There were significant concerns expressed about emergency department (ED) access block leading to ambulance ramping across South Australia's major metropolitan hospital sites. It was discussed that South Australia is one of the worst performers on this metric nationwide. The ED access block is likely having significant detrimental effects on both patient outcomes and staff morale. In this context, specific concerns were expressed about the very long wait times for mental health patients requiring acute inpatient beds, particularly at the Royal Adelaide Hospital and Queen Elizabeth Hospital. The specific requirement for ED mental health waiting time targets for mental health (including monitoring 24-hour breaches) and clear accountability for this issue was specifically canvassed.

In relation to rural and regional issues an update was provided in relation to the ongoing negotiations between AMA(SA) and SA Health in relation to remuneration and conditions.

The June meeting was the first to be led by new Chair Dr Peter Subramaniam. Dr Subramaniam has assumed the Chair with the election of former Chair, Dr Michelle Atchison to the presidency of AMA(SA).

New AMA(SA) Council Chair Dr Peter Subramaniam

Practice makes perfect

AMA Skills Training was able to stage its annual 'Essentials of Practice Management' workshop in May after COVID-19 led to the session's cancellation in 2020.

The full-day workshop was held on 14 May 2021 at Adelaide Royal Coach Motor Inn.

Presentations from numerous speakers included:

- political correctness and the impact of social media in the workplace
- working in the Return to Work scheme
- 'Being on the best team' – team effectiveness and building a positive work culture
- advertising, marketing and promotion risks – understanding Ahpra advertising guidelines and how they apply in practice
- authentic leadership
- meditation in the workplace.

ReturntoWorkSA's Julianne Flower outlines the Return to Work scheme

Positive feedback received from the 15 attendees – who gathered from medical, allied health and dental workplaces – noted that it was a very informative and productive day, and a great opportunity for networking.

AMA Skills Training Manager Michelle Cockshell thanked the sponsors for the event: ReturntoWorkSA, MIGA, Norman Waterhouse and Smith Sterilising.

AMA Skills Training can tailor professional development workshops for your practice and staff. Enquiries can be directed to training@amaskillstraining.org.au or by phone to 8361 0141.

AMA Skills Training trainer and assessor Vicki Linden presenting 'Being on the best team'

A recent survey of AMA Skills Training graduates has demonstrated widespread satisfaction with training content, support services and trainer expertise.

The survey asked 60 graduates to respond to questions about their satisfaction with AMA Skills Training programs. Responses were received from 30 graduates.

Training Manager Mrs Michelle Cockshell said the results showed 90.7 per cent of the respondents would recommend AMA(SA) as a Registered Training Organisation to others.

Mrs Cockshell says the results vindicated the efforts of training staff in developing and delivering much-needed health care, medical administration, and other training.

'We work closely with doctors, practice managers, service providers and other organisations so we can offer training they need for their businesses and workplaces,' Mrs Cockshell says.

For more information go to the AMA Skills Training website.

An essential service

After nearly 20 years of service, Dr Michael Rice is retiring as head of the Medical Benevolent Association of South Australia.

Outgoing chair of the Medical Benevolent Association of South Australia Dr Michael Rice

The Medical Benevolent Association of South Australia (MBASA) was established in 1881 as an off-shoot of the South Australian branch of the British Medical Association, which had been formed in 1879 after the dissolution of the South Australian Medical Society. The new association aimed to help doctors and their families in distress – objectives that continue to the present day.

The current MBASA Constitution states that the MBASA aim is 'to assist medical practitioners who practise, or in the opinion of the Board have previously practised predominantly in South Australia, who are suffering financial hardship due to mental or physical disability or infirmity' and 'to assist spouses and/or children who are suffering financial hardship due to the mental or physical disability, infirmity or death of a medical practitioner who has practised predominantly in South Australia'.

MBASA has had a long and productive relationship with AMA(SA), which provides secretarial support and managing financial and other records of MBASA. This relationship was formalised in 2020 when both parties signed a a Memorandum of Understanding.

MBASA is governed by a Board of Trustees. The current Board members are Drs Janice Fletcher, Peter Ford, Bill Heddle, Peter Joseph, Jill Maxwell, Patricia Montanaro, Rodney Pearce and me – all former AMA(SA) Presidents – along with former AMA(SA) treasurer John Wyett. Trustees tend to be long-serving; there have been only nine chairs in the association's 140-year history.

As I relinquish my role as MBASA chair and reflect on my experience during the past 19 years, three issues warrant comment.

Firstly, the medical profession is certainly not immune from the maladies that affect the broader community: MBASA has been asked to assist families affected by suicide, domestic violence, the ageing process, unexpected illness, and sudden death.

Secondly, because our financial resources are limited, the association's capacity to help individuals and families is restricted to short-term support. During the past decade, we have been extremely grateful for the financial support offered by the South Australian Chinese Medical Association, Avant Medical and a small number of individual donors. However, more support from the medical profession at large would be greatly appreciated (and is tax deductible).

Finally, MBASA strongly recommends that all medical practitioners have personal income protection insurance and an effective financial plan. An up-to-date will is also essential – more than once, the Board has been asked to help families facing significant difficulties, albeit usually short-term, because of the absence of a will.

My successor as the tenth chair of MBASA is Dr Jill Maxwell. Jill has been an MBASA trustee for many years and is well versed in the workings of the association. I wish her well in her new role.

Private practice

The release of information about children, and to whom, can be a headache for doctors in custody disputes, writes MIGA's Anthony Mennillo.

Anthony Mennillo, MIGA's Senior Manager – Legal Services

One of the most common medico-legal enquiries that arise for practitioners who see and treat children is a parent's entitlement to information about their child or children, particularly if parents are separated. Without a considered approach to the situations before them, doctors may find themselves caught in the middle of bitter custody disputes or expose themselves to privacy breaches. The following case study highlights the issues that can arise.

John and Sue had been separated for one year. Sue attended the local general practice, where she had consulted Dr Jones for many years. She also brought her three children aged 12, 10 and eight to see Dr Jones. The children were always brought to the surgery by Sue.

Dr Jones receives a phone call from John, the children's father, requesting information about treatment of the children. John said that he and Sue were involved in a bitter custody battle and that she would not provide him with any information about the children.

Dr Jones had never met or spoken to John and was not sure whether he should be releasing information to him.

PARENTS' ENTITLEMENT TO INFORMATION REGARDING THEIR CHILDREN

The Commonwealth *Privacy Act 1988* grants patients a general right of access to their health information. In relation to children, the *Australian Privacy Principles* state that a health service provider may disclose health information about a child to a person responsible for the child, and this includes a parent. The Principles require the health service provider to consider the child's privacy before releasing personal (and sensitive) information to any parent, despite the child's age. There may be circumstances where disclosure of information to a parent is not appropriate.

THE *FAMILY LAW ACT*

Section 61C of the *Family Law Act* provides that each of the parents of a child who is not 18 has 'parental responsibility' for the child. Parental responsibility is defined as 'all the duties, powers, responsibilities in authority which, by law, parents have in relation to the children'. The Family Court of Australia has stated that '(t)he capacity to meet parental responsibility towards children must carry with it some knowledge as to the progress of children and their needs'.

The Family Court of Australia has also indicated that:

'When the parent of a child who has responsibilities cast upon them for the protection of the child seeks information concerning the child's welfare and progress, it would seem that unless it was positively demonstrated that the provision of such information might be detrimental to the child, that information should be made available'.

The *Family Law Act* states that parental responsibility is not affected by the parents becoming separated or by either or both marrying or remarrying.

However, that legal position is subject to any parenting order made by the Family Court or a 'parenting plan' put in place by the parents. If a parenting order or parenting plan states that only one of the parents is to have access to medical information, the other parent is not entitled to access the information.

Dr Jones sought advice about the scenario above from his medical indemnity insurer, in this case MIGA. We advised:

- the overarching consideration should be the best interests of the children
- while either parent may be entitled to medical information about their child, there may be reasons for information to be withheld from one parent (or, less frequently, both parents)
- Dr Jones is entitled to withhold information from either parent if the disclosure of the information may pose a serious threat of harm to the child or others. For example, if he knows that one parent has been or is abusive towards their former spouse and/or the child, it may be in the child's best interest not to disclose any information that would identify the child's location or contact details
- Dr Jones may contact Sue as the primary care giver and enquire whether there is a parenting order or parenting plan to prevent John accessing information about the children, and, if there is, to obtain a copy of that document to satisfy himself of the orders
- if there is no such order, Dr Jones should ask Sue whether John should not have access to the information; for example, if John is restricted from having access to information about the whereabouts of Sue and/or the children, or if a restraining order is in place
- if Dr Jones has concerns about the disclosure of medical information about the children to John, it can be withheld. John can then approach the Court to decide the matter.

If you are in unsure of your obligations or the most appropriate course of action in a particular situation, you should seek advice from your medical indemnity insurer.

Anthony Mennillo is MIGA's Senior Manager – Legal Services.

FROM OUR PARTNERS

HOODSWEENEY
join the journey

Act before terms change

South Australians considering new income protection insurance should act quickly if they want policies to consider earnings beyond the past year, writes Hood Sweeney adviser Mark Mullins.

Mr Mark Mullins of Hood Sweeney

The benefit structure for income protection insurance policies is slated to be tightened in 2021 as insurers aim to stem the billions of dollars the industry loses each year.

The latest proposed change will reduce the period of income history that insurers consider when you make a claim.

It is proposed that new income protection policies will consider only the income earned in the 12 months immediately before the life-changing incident that prevents you from continuing to earn an income. This compares to existing policies, which consider three years' earnings before a claim.

If you do not have income protection, you may want to act quickly to lock in a policy with the more favourable three-year term.

Income protection insurance, also known as disability income insurance, can provide policy holders with replacement income when they are unable to work due to illness or injury. As it stands, it can protect a family financially in the event of debilitating injury or illness, providing a replacement income and allowing time for recovery without the added stress of mounting bills.

Three years versus 12 months may not seem like a huge difference. But consider this: COVID-19 has decimated earnings for many people in 2020 and 2021. If you were to have an accident now, and your policy considers only the past 12 months' earnings, you would be paid at a rate based on an unprecedented, pandemic-driven 12 months of reduced earnings.

Likewise, taking time off for maternity or paternity leave, when income is shrunk, can influence a policy pay-out.

The Australian Government's statutory authority, the Australian Prudential Regulation Authority (APRA), has summoned the life insurance industry to address concerns about the sustainability of individual income protection insurance.

APRA has been concerned about income protection insurance due to the leniency of claims. The industry has collectively lost $2.5 billion through this product offering over the past five years, with no signs of improvement.

As of 31 March 2020, APRA required insurers to stop selling 'agreed value income protection' policies. The policies introduced since that time are based on 'indemnity value'. This means the benefit value of your policy is determined by your income at the time of a claim rather than being set at the time you take out the policy. This increases the risk of you receiving a smaller pay-out than the insured benefit, if you are unable to provide undeniable proof of your income at the time of the incident.

There are many questions to consider, based on your individual circumstances. If you are thinking about income protection, talk to a Hood Sweeney specialist about the policy options available to you. Call 1300 764 200 or email Mark Mullins.

Mark Mullins
Director and Representative of Hood Sweeney Securities Pty Ltd, AFSL No. 220897
mark.mullins@hoodsweeney.com.au

Dr James Muecke

- Ocular surface and intraocular tumors
- Medical retina (age-related macular degeneration (AMD)
- Diabetic eye disease
- Retinal Vein Occlusion
- Retinal tears

Associate Professor Jolly Gilhotra

- Medical retina (age-related macular degeneration (AMD)
- Diabetic eye disease
- Retinal tears
- Retinal Vein Occlusion
- Surgical retina (retinal detachment, epiretinal membrane, macula hole, vitreous haemorrhage)
- Uveitis
- Cataract surgery

Dr Shane Durkin

- Medical retina (age-related macular degeneration (AMD)
- Diabetic eye disease
- Retinal tears
- Retinal Vein Occlusion
- Surgical retina (retinal detachment, epiretinal membrane, macula hole, vitreous haemorrhage)
- Cataract surgery

Adelaide Eye and Retina Centre are pleased to welcome our new associates Dr Michelle Baker and Dr David Sia to the team.

Dr Baker's specialties include:

- Management of glaucoma
- Laser treatment for glaucoma
- Minimally invasive glaucoma surgical techniques
- Trabeculectomy
- Novel glaucoma devices

Dr Sia's specialties include:

- Ocular Oncology
- Cataract
- Medical retina
- Surgical retina

Adelaide Eye & Retina Centre have private consulting rooms in Adelaide and Plympton Park. We welcome referrals for new patients at both clinics and have regular reserved appointments to ensure availability for emergencies.

Adelaide Eye & Retina Centre is one of the only clinics in South Australia currently involved in numerous clinical trials creating opportunities for patients to be at the forefront of ophthalmic care whilst utilising our leading-edge technology which is available within our clinics.

The Adelaide Eye and Retina Centre has been proudly providing quality specialist eye care to the metropolitan and rural communities of South Australia since 1998. Our primary goal is to obtain the best possible outcomes and satisfaction for our patients. We have a passion for treating patients using the best available techniques, equipment and evidence-based practices

For all appointments and enquiries contact **08 8212 3022** or email **admin@adelaideeye.com.au**
You can also fax our team on **08 8212 3302**

Adelaide: Level 2, 18 North Terrace, Adelaide
Plympton Park: 530 Marion Road, Plympton Park

www.adelaideretina.com.au | T 08 8212 3022

ADELAIDE EYE & RETINA CENTRE

Personal choice

Motoring writer Rob Menz decides to put his money where his preference lies.

Dr Robert Menz with his Subaru Forester

One of the questions I am asked in my role as a medical motoring writer is, 'Do the articles that appear in *medicSA* influence new car choice?

If your answer is 'yes', we would really like to know. And as the answer has been 'yes' for me, I thought I would share my story with you at this edition.

Some readers may remember the report on the Subaru Forester in 2019. Since that report there have been some significant changes to the Forester line-up. First, as foreshadowed then, there has been the introduction of a hybrid option. This is currently available only on the base model and top-of-the-range S models, and it adds about $3,000 to the purchase price.

Although I have not driven the hybrid, reports suggest there is little advantage over the non-hybrid model in terms of either performance or fuel economy – and there is the disadvantage of having no spare tyre. The hybrid engine is a 2 L 110 kW petrol engine supplemented by a 22 kW electric motor.

Another change is the introduction of a sport model that slots between the premium and S models. In this case 'sport' refers to appearance only, as the engine is the same as others in the non-hybrid line-up, namely a 2.5 L 136 kW boxer engine. Some of the cosmetic changes on the sport model include black wheels and bright orange work around the bars and mirrors and air conditioning outlets.

Another improvement over the previous model is an increase of 300 kg in towing capacity, which is now 1,800 kg (1,200kg in the hybrid models) and should broaden the Forester's appeal.

Even the base model Forester comes with sophisticated safety features, including adaptive cruise control, Subaru's 'vision assist' and 'eyesight driver assist', and a push-button engine start. The top spec S model also includes refinements such as a dipping side mirror when reversing, tracking headlights to help see around corners, a leather interior and heated front seats, and sophisticated avoidance systems. One really neat feature is that the interior light comes on when you approach within a metre of the driver's door, provided you have the key in your pocket. Each of the non-hybrid Foresters also includes a full-sized spare tyre and a CD player; two features increasingly missing from modern cars.

So, what is it like to drive?

As reported in 2019, the Forester is a very competent machine. It is quiet and easy to drive around the city and easy to park. Using the adaptive cruise control ensures you always stay a certain distance behind the car in front, even at red lights. The elevated driving position gives an excellent view through the large windows.

Likewise, freeway driving is very straightforward. The Forester handles winding hills roads with aplomb and the permanent four-wheel-drive gives an extra degree of confidence on wet, slippery, or unsealed roads. The generous 500L boot easily accommodated the paraphernalia for a long-weekend trip to Port Augusta to visit my new granddaughter. If more space is required, folding down the rear seat backs gives more than 1,750 L of space.

The Forester comes with a five-year unlimited kilometre warranty and fixed-priced servicing.

Would I buy a Forester for my own use? Well, yes, I did! And after two months I'm still enjoying the new car smell.

Dr Robert Menz is a GP who has recently purchased his third Subaru

Inner dialogues and world views

Changing our world view starts with questioning the stories we tell ourselves, writes Dr Troye Wallett.

Dr Troye Wallett is a GP who frequently questions his world view. If you have any views to discuss, email him at troye@troyewallett.com

'Ninety-five per cent of our reality is dictated by how you view the world.'

Professor Shawn Achor, Harvard Professor of Psychology

As we walk through our lives, the narrator in our heads commentates. It interprets what we see, hear, smell and experience and turns it into a story. Two people walking side by side, who experience the same stimuli, will experience different realities. Their inner dialogue uniquely interprets the world based on their personality, cognitive biases, and life experiences.

Emails are a classic example. How many times have we read an email and interpreted the tone as irritated or angry? Tone is hard to read, and the person may have just been tired or stressed. An email with the same content can come across as aggressive to one person or 'to the point' to another. It depends on their world view.

'Never put down to malice that which can be put down to fatigue or stress.'

Tim Ferriss, author and podcaster

Imagine a friend, Tom. When Tom's mood deteriorates, his internal narrator starts to tell him the story that no one cares for him. He looks around and sees that people are busy, introspective, and generally do not care about others. They care when confronted by something to care about, but the care is quickly forgotten. 'And why should people care - everyone lives complicated and busy lives, and there is no reason for them to care?'

The thought process does not bother him when his mood is good, but on the darker days, it burns. Tom's narrator ruminates on this worldview, especially when he is feeling down.

OUR INNER VOICE CONFABULATES

The thing is that the narrator confabulates. It tells stories to fit what it perceives, but it really has no idea and makes it all up.

There is a study where the candidates are asked to choose their preferred stockings among five presented to them. Because of 'recency bias' - the cognitive bias that overweighs recent events over ones that happened in the past - most pick the fourth or fifth pair.

The study becomes interesting when the candidates are asked why they made their choice. Not one said, 'Recency bias!'. The reasons ranged from preferring the texture to liking a darker black. However, all the stockings were the same!

PROVING THE HYPOTHESIS

It is becoming more and more understood that our inner voice interprets the world and presents hypotheses. But often, those hypotheses are wrong.

Once the narrator presents a hypothesis, we subconsciously look for examples to prove it. But it is a self-fulfilling prophecy: we cannot help but find the proof, in the same way a person who decides to buy a Jaguar XJ series car sees them everywhere. It is 'frequency bias' - a cognitive bias in which, after noticing something for the first time, there is a tendency to notice it more often.

Tom's mood is down, and he is feeling very uncared for. He comes home from work, makes dinner for the family, and is not recognised for the effort. He is getting ready for bed, and his pyjamas are old and tatty. His inner voice says, 'No one ever spontaneously buys me gifts or recognises that I need things'. Because he is conscious of his thoughts, he considers his inner dialogue and thinks it sounds pathetic, which causes his mood to deteriorate further.

His hypothesis that no one cares is proven as he is subconsciously looking for it. It is a cycle of belief, confirmation, stronger belief.

BREAKING THE CYCLE

Our reality is dictated by our world view, and our world view is dictated by the narrator. Our narrator presents questionable hypotheses that are proven by our cognitive biases. Therefore, our experience of life is malleable. This can be used to our advantage. If it is possible that our world view flawed because it is based on false assumptions, there is an opportunity to change it and choose what to believe. It can have a significant impact on how we walk through the world.

What does this tell us about our ability to shape the world more positively? Firstly, that it is possible to consciously choose a different hypothesis. Tom is fortunate to have a generous, beautiful and wise friend who opens his eyes to the ideas in this article. He decides to test the hypothesis that people do care.

The next step is to commandeer frequency bias to consciously look for proof.

Tom chooses to look for moments and proof of care. The next day, he is amused to see a number plate on a car that says *CARE21*. It is not the proof he is looking for but is proof that he has triggered frequency bias. Over the next few weeks, he notices that a friend phones him spontaneously, his kids hug him daily, and he remembers a gift given to him a few months ago. He is building proof for a new hypothesis.

The process is slow and is not a dopamine-driven, ground-breaking change. But after a few weeks, Tom realises that the 'no one cares' narrative starts to feel less true.

ACTION

When asked by the media if they are nervous before the race, Olympic athletes reply, 'Nope, I was excited!'. They have learned to tell a different story about their feelings.

Writing a gratitude journal every evening has been shown to improve a person's outlook and mood. The habit is a formal process to prove there is much to be grateful for in contrast to the belief that life is hard.

Here is the upshot or the 'TLDR' ('too long, didn't read') version:

- 95 per cent of our reality is dictated by our world view
- Our world view is dictated by an internal narrator who should not be believed.
- The frequency bias leads to a world view strengthened by our observations. It is a cycle of belief, confirmation bias, strengthened belief.
- We can choose our world view and choose to observe or look for proof in a new (more true?) reality.
- Set a new world view. Look for proof.

It is simple and effective: decide how you want to experience your world and look for proof. Most likely, you will find it; if not, you can use that as proof that the world is gloriously fascinating, and start from there.

2021 AMA NATIONAL CONFERENCE - SAVE THE DATE

The 2021 AMA National Conference will be a virtual conference, held over three evenings and one day – the evenings of 28, 29 and 30 July, and a full day on Saturday, 31 July 2021.

If you have any questions or issues please contact natcon@ama.com.au.

PREPARING FOR PRIVATE PRACTICE

Are you considering going into or setting up for Private Practice? Do you know where to start?

AMA(SA) is offering a seminar to members, presented by our preferred providers Hood Sweeney to help get you started. Visit the AMA(SA) website.

AUGUST COUNCIL MEETING

The next meeting of the AMA(SA) Council will be held on the evening of Thursday, 5 August 2021. If you are a member and wish to attend the August meeting, please call 8361 0100 or email admin@amasa.org.au

SAVE WITH YOUR AMBASSADOR CARD

Current financial members can take advantage of Australia's premier member benefits program, The Ambassador Card, which is your key to savings with over 3,500 benefits.

This is a digital program and can be accessed through the AMA(SA) website go to the Membership tab under Benefits and Services and login using your SA membership ID number and your email address as the password.

The Ambassador Card also has a regular monthly competition and regular 'hot offers'. Search categories include gift cards, tickets and attractions, shopping, accommodation & travel, food & wine, leisure, finance & insurance, health & wellbeing, education & courses, auto, home services and you can also search by state and regions.

DO WE HAVE YOUR CORRECT MEMBERSHIP DETAILS?

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

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

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

HAMILTON HOUSE

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

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

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

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

DR MICHAEL SANDOW

Associate Professor Michael Sandow BMBS, FRACS, PhD, Orthopaedic Surgeon, wishes to advise that he is now consulting in hand/wrist/elbow/shoulder disorders and injuries at Summit Health Centre, 85 Wellington Road, Mount Barker. He continues to consult at his main rooms at Wakefield Orthopaedic Clinic, Level 2, 120 Angas Street, Adelaide, and at Golden Grove Specialist Centre, 205 The Golden Way, Golden Grove. All appointments and enquiries via the main office on 08 8236 4166, or adminsandow@woc.com.au. Further details at www.woc.com.au.

DR SUSAN NEUHAUS

DR SUSAN NEUHAUS FRACS wishes to advise that effective 1 July 2021 she will cease private surgical practice at Adelaide Plastic Surgery.

Dr Neuhaus wishes to thank providers, referrers and colleagues for their support and shared care of patients over many years.

Existing patients will be provided with an individual continuity of care plan and/or onwards referral as appropriate. The Royal Adelaide Hospital provides a Trauma/General Surgery and Surgical Oncology Unit (Ph: 1300 153853) for patients with sarcoma and soft tissue tumours, melanoma, other surgical malignancies and general surgery.

DR CHRISTOPHER WURM

Christopher Wurm, MB BS FRACGP FAChAM, Specialist in Addiction Medicine, will move his weekly private session from Florey Healthcare, Pooraka, to Paragon Medical Centre, 97-105 Smart Road, Modbury, SA 5092 in September. Tel: (08) 8264 7824, Fax (08) 8263 1519. Correspondence by HealthLink: drchrisw

He continues to work for SA Health at 221 Main North Road, Sefton Park, Tel: (08) 8342 8600, Fax (08) 8342 0053. All referrals for private driver's license reports must be sent to Paragon Medical Centre by fax (08) 8263 1519.

No commercial vehicle or CASA reports. Copies of relevant, recent blood and urine tests would be appreciated.

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Contact us

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