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MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. OCTOBER / NOVEMBER 2018



State election priorities

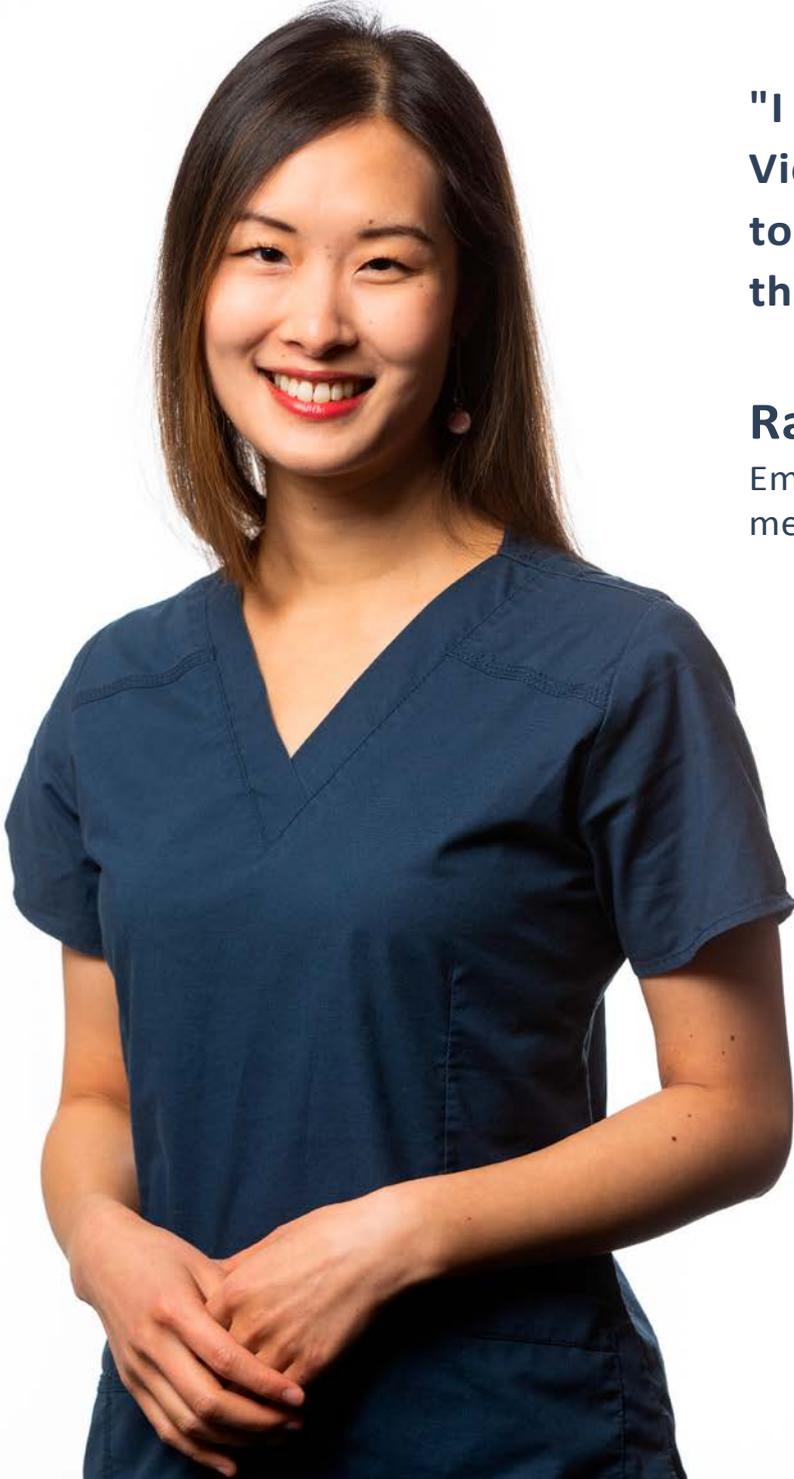
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Welcome from the editor

Magazine of the Australian Medical Association Victoria

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Dr Anna Power and Dr John Floyd share medical stories from different eras through our Peer Visitor Program. See page 24.

It's a particularly busy time at AMA Victoria, as we move into the last quarter of the year with a big focus on the Victorian State Election.

Our President, A/Prof Julian Rait, and the Board, along with our Policy and Public Affairs team, Sections of General Practice and Psychiatry, and Policy and Doctors in Training subcommittees, have been working hard on AMA Victoria's priorities for the state's health system in the lead-up to the vote. We are calling for action to be taken to address significant gaps in a number of key areas including mental health, rural and regional health, public hospital culture and infrastructure, drug and alcohol rehabilitation services and palliative care.

AMA Victoria will maintain sustained advocacy on these goals and will continually monitor the delivery of change and outcomes, throughout the term of the next government, and keep our members well informed about the progress.

Our dinner with State Health Minister, Jill Hennessy, was very well attended in late September and members also have the

opportunity to hear from the Shadow Minister for Health, Mary Wooldridge, at another dinner on 1 November. Please see our website for more details.

This edition of Vicdoc has been sent to all Victorian doctors. If you are not currently a member, this magazine highlights some of the invaluable services you are missing out on. You can also learn about the priorities for AMA Federal President, Dr Tony Bartone, in what shapes as an eventful build-up to the looming federal election. Improving the landscape for GPs is a big focus.

If you would like to tell us about an achievement in medicine or a personal interest others might enjoy reading about, please contact me on the details below. Vicdoc is sent to members every two months, so look out for the next edition in your mailbox in early December.



Barry Levinson

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President's message

It has been a relatively smooth transition for our new Board during the past four months with the very welcome addition of our new Chief Executive, Steven Burrell, to our team during September. AMA Victoria, alongside our Federal branch, has been working hard on several priorities in the pursuit of greater fairness in the treatment of doctors, including the implementation of new public hospital enterprise agreements, advocating for a better deal for GPs and attempting to stabilise the private health insurance sector.

As our public hospital colleagues will be aware, enterprise bargaining negotiations were successfully concluded after a final meeting between AMA Victoria and the Victorian Hospitals' Industrial Association in July. These historic agreements were then approved by the Fair Work Commission and became effective on Tuesday 7 August. We have since received reassurance from the Department of Health and Human Services that additional recurrent funding to public hospitals will be released to support the implementation of these agreements. AMA Victoria now looks forward to working with state hospitals and the Victorian Government to improve working conditions in public hospitals. By ensuring that hospitals continue to be staffed by well-supported junior and senior doctors, we expect that the improved pay and conditions will deliver greater job satisfaction for doctors and better care for our patients.

AMA Family Doctor Week highlighted the central role that GPs play in our healthcare system. AMA Victoria promoted the stories of a number of our GP members who have well-served their communities and provided essential care over many years. In addition, the issue of access to GPs that has long plagued many Victorian country communities received media attention via *ABC News* in August. It followed the release of data by the Victorian Rural Workforce Agency revealing that 67 GP positions were vacant in Western Victoria, 77 in the Murray and 32 in Gippsland. Concerningly, we observed that these figures actually underestimated the true extent of the shortage as they didn't include positions available through commercial job websites. Consequently, the real number of vacancies in each region of Victoria is very likely to be much higher.

Although the Medicare freeze has recently been lifted, AMA Victoria has argued that this misguided policy has disproportionately affected GPs. In fact, we believe that the freeze has had a devastating impact

on the ability of all general practices to attract and retain GPs in Victoria. It's prompted us to lobby for an immediate and generous reinvestment in general practice, in order to reinvigorate this cornerstone of our healthcare system.

Another strength of Australia's health system is the balance of public and private health. In fact, 70 per cent of elective surgery occurs in private hospitals, so our public hospitals simply wouldn't cope without the support of our private system. Therefore, the two systems must continue to complement each other.

Indeed, the AMA has welcomed proposed new rules that will underpin reforms to the private health insurance (PHI) system, including a new classification system for insurance coverage. Over the past two years, we have been at the table working alongside the Federal Government, insurers, consumers and hospital groups, in an attempt to develop the Gold, Silver and Bronze classification system and ensure that these reforms deliver greater clarity, fairness and transparency.

Consequently, the AMA believes that the proposed Private Health Insurance Amendment Rules 2018 contain some positives, including greater clarity about which medical conditions are covered in each tier of benefits, full mandatory cover for the medical conditions in each tier and the use of standard clinical categories across all private health insurance policies.

However, we are deeply disappointed that after two years of hard work the Federal Government only allowed less than three weeks for the evaluation of the final details of the new system. Good policy development requires thorough and considered deliberation. Adequate time and sound modelling are critical to ensure that usual clinical pathways have been adequately protected and that essential elements for the treatment of a condition have not been overlooked.

It is a common misconception that the doctor's fee is the reason for many out-of-pocket costs. However, as most AMA members know, the benefit that a surgeon receives will vary widely by insurer, policy, procedure and after the latest changes initiated by BUPA, it might even vary according to the treating hospital. Therefore, a key issue not covered by the new scheme is the adequacy of these fee payments to medical practitioners. The AMA continues to argue that, like the Medicare rebate freeze for consultations, the levels of benefits paid to surgeons



and anaesthetists by health funds through PHI have not matched the rising cost of providing these services. These amounts have been largely based on MBS rates where the Medicare schedules have been frozen for the last five years and prior to this, they had not been appropriately indexed for many years. Currently the table of PHI rebates bears no relationship to the reality of providing high quality surgical and anaesthetic care in Australia.

The AMA has stated strongly to the Department and to the office of Federal Health Minister Greg Hunt

that a longer, more rigorous process will be needed to properly develop this scheme. It simply cannot be done without consulting the expertise from the colleges, associations and specialist societies. Without doing so, arguably the most critical component of the private health reforms will fail and ultimately our patients will suffer. Our role is to call loudly and strongly for this to be avoided. Equally, AMA Victoria will continue to pursue a fair go for all doctors.

A/Prof Julian Rait
President

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Health reform: Improving the patient journey



AMA Federal President Dr Tony Bartone addressed the National Press Club in Canberra on 25 July about his priorities for the medical profession. The following is an excerpt of his speech.

I am a GP and I have been in practice in the northern suburbs of Melbourne for more than 30 years. Some of you may know that I was inspired to become a GP by watching my own family doctor, who cared for my ill father when I was growing up. Even now, my mother reflects on the care and dedication my family GP displayed in caring for her family. It's no surprise that he became an early mentor in my professional life.

I have seen it all as I have looked after the health of my community and my patients, including generations of the same families. I like to think that my experience has given me some credibility in knowing what works

and what doesn't work in the health system, especially in primary care.

My overarching concern has always been the patient journey - ensuring that people get the right care at the right time in the right place by the right practitioner. The priorities for me are always universal access to care and affordability.

General practice and primary care reform

On the day I was elected, I made it very clear that one of the hallmarks of my presidency would be stridently advocating for significant investment

in general practice. GPs of Australia, I salute you. We all salute you. Your hard work and dedication is highly valued. The AMA will always support you and promote you.

Your GP - your family doctor - will ensure that your health needs are met throughout all stages of your life. Be it immunisation, preventative healthcare, age specific medical checks, chronic disease management, or aged care, the life long relationship with your GP underpins continuous and appropriate care. This is especially the case for patients who are from culturally or linguistically diverse backgrounds. For them, GPs truly are their trusted health advocates.

However, there is something really crook about how GPs have been treated by successive governments. They have paid lip service to the critical role GPs play in our health system, often borne out of ignorance and often in a misguided attempt to control costs.

General practice has been the target of continual funding cuts over many years. These cuts have systematically eaten away at the capacity of general practice to deliver the highest quality care for our patients. They threaten the viability of many practices.

I talk to my GP members regularly, both metropolitan and rural. The message is simple - some are at a tipping point and have a very bleak view of the future. They see general practice becoming increasingly corporatised, burdened with more red tape, and GPs are less able to spend the necessary time with patients.

This is not the future that GPs want to see. This is not the future that our patients want to see.

We can and must avoid these bleak predictions, but it requires significant real and immediate investment from the Federal Government with a clear pathway to long-term reform. Let me be very clear about this: we must put general practice front and centre in future health policy development.

We have seen too many mistakes. Too many poor policy decisions. Despite the Government's best intentions

- and lots of goodwill within the profession - the Health Care Homes trial and implementation failed to win the support of GPs or patients. Instead of real investment, the trial largely shifted existing buckets of money around. It has fallen well short of its practice enrolment targets and it looks like only a small fraction of the targeted 65,000 patients will sign up.

There is no doubt that the challenge of transforming general practice was severely underestimated by policy makers; at least with this model. But general practice still needs transformation and rejuvenation to meet growing patient demand and to keep GPs working in general practice.

The AMA has a plan for reform of general practice and primary care. It is patient-centred and focuses on better access to long-term continuous quality care and managing patients more effectively in the community. It takes the best elements of the 'medical home' concept and adapts them to the Australian context.

It is a plan that will require upfront and meaningful new investment, in anticipation of long-term savings in downstream health costs. In the short term, the AMA plan for general practice will involve:

- significant changes to chronic disease funding, including a process that strengthens the relationship between a patient and their usual GP, and encourages continuity of care
- cutting the bureaucracy that makes it difficult for GPs to refer patients to allied health services
- formal recognition in GP funding arrangements of the significant non-face-to-face workload involved in caring for patients with complex and chronic disease
- additional funding to support enhanced care coordination for those patients with chronic disease who are at risk of unplanned hospital admission - a similar model to the Coordinated Veterans' Care Program funded by the Department of Veterans' Affairs

- a properly funded Quality Improvement Incentive under the Practice Incentive Program (PIP)
- changes to Medicare that improve access to after-hours GP care through a patient's usual general practice
- support for patients with chronic wounds to access best practice wound care through their general practice
- better access to GP care for patients in residential aged care
- annual indexation of current block funding streams that have not changed for many years, including those that provide funding to support the employment of nursing and allied health professionals in general practice.

In the longer term, we need to look at moving to a more blended model of funding for general practice. While retaining our proven fee-for-service model at its core, the new funding model must have an increased emphasis on other funding streams, which are designed to support a high performing primary care system.

This will allow for increasing the capability and improving the infrastructure supporting general practice to allow it to become the real engine room of our health system. It is about scaling up our GP-led patient-centred multidisciplinary practice teams to better provide the envelope of healthcare around the patient in their journey through the health system.

A good example is the Blacktown Hospital Diabetes Outpatient Clinic in New South Wales. This clinic has a waiting time of less than a week because the service is distributed to its catchment GPs with the appropriate funding and support for both personnel and infrastructure. This is a small example, but a significant one when you consider the scale and prevalence of diabetes across Australia, let alone the western suburbs of Sydney and the average access times for outpatient hospital clinics.

Continued on page 10



We cannot continue to do things the way we always have. The bulk-billing rate should not be the metric by which we judge the performance of general practice. Chronic conditions have become more prevalent in Australia. The ones causing most concern are:

- arthritis
- asthma
- back pain and problems
- cancer
- cardiovascular disease
- chronic obstructive pulmonary disease
- diabetes
- mental health conditions.

One in two people now report having at least one of these eight common chronic conditions. These conditions account for around 60 per cent of the total disease burden and they contribute to nearly 90 per cent of deaths in Australia.

We must reshape our primary care system to meet these challenges. We must put in place the funding support that general practice needs to better manage patients in the community - and keep people out of hospital. Our

plan is a smarter and more sustainable blueprint; a better plan for general practice. A better plan for Australians.

Mental health

As a suburban GP who sees the whole range of health ailments and conditions, an area of special interest to me is mental health. I do not think the unique role and special skills of GPs are used enough at the front line of mental healthcare.

The AMA earlier this year called for a national, overarching mental health "architecture" and proper investment in both prevention and treatment of mental illnesses. Almost one in two Australian adults - that is more than seven million people - will experience a mental health condition in their lifetime.

Almost every Australian will experience the effects of mental illness in a family member, friend, or work colleague. The statistics are startling. For example:

- More than half a million children and adolescents, aged four to 17, experienced mental health disorders in 2012-13.

- Australians living with schizophrenia die 25 years earlier than the general population, mainly due to poor heart health.

And yet mental health and psychiatric care are grossly underfunded. Strategic leadership is needed to integrate all components of mental health prevention and care.

For mental health consumers and their families, navigating the system and finding the right care at the right time can be difficult and frustrating. There is no vision of what the mental health system will look like in the future.

Poor access to acute beds for major illness leads to extended delays in emergency departments. Poor access to community care leads to delayed or failed discharges from hospitals. And poor funding of community services makes it harder to access and coordinate prevention, support services and early intervention.

Significant investment is urgently needed to reduce the deficits in care, fragmentation, poor coordination, and access to effective care. We have repeatedly called for support for carers of people with mental illness, which

Continued on page 12

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is often the result of necessity, not choice. Access to respite care is vital for many people with mental illness and their families, who are the ones who bear the largest burden of care.

Prevention

There is not enough time to cover all the issues I would like to cover in one speech. I could deliver a whole speech on each of the following topics - medical workforce, rural health, medical research, genetic testing, e-cigarettes and vaping, opioids, medicinal cannabis, scope of practice, asylum seeker health, the NDIS, or palliative care, to name just a few.

But I have to talk to you about prevention, if only briefly. The burden of chronic disease in Australia is significant. Chronic disease is responsible for around 83 per cent of premature deaths and 66 per cent of the burden of disease.

Chronic disease has a significant impact on the health system, but the reality is that most of these conditions can be prevented. It simply makes enormous sense to invest in prevention. Taxes collected from tobacco and alcohol excise

generate around \$16 billion each year for the Government. In return, total Government spending on prevention is around \$2 billion a year, which equates to about \$89 per person. This amounts to a measly 1.34 per cent of all health spending. This is considerably less than comparable countries such as Canada, the United Kingdom and New Zealand.

If we are to reduce the impact of chronic disease in Australia, all our governments must invest more in prevention.

Tackling obesity is a priority. Doctors are well placed to identify and support patients who are overweight or obese. Two thirds of adults are either overweight or obese. The evidence shows that advice to lose weight given by a doctor increases the motivation to lose weight. It also increases engagement in weight loss behaviours. But the support and advice from doctors can only achieve so much.

Population level measures are needed. We need to see action on a sugar tax, banning junk food advertising to kids and improving urban planning to help get people moving and active. Governments have the tools to implement these measures. A sugar tax would be a good start.

In closing, I know the challenges ahead for the health system. I will dedicate my Presidency to improving health policy so that we have a system that delivers the best possible care to our patients.

The AMA will be a very strong and loud advocate. There is nothing like a federal election to help our political leaders share the public's interest in good health policy. The election will happen within 12 months, possibly this year. Along with the members of the National Press Club, the AMA will be watching the political events of the coming months with very close interest.



Visit ama.com.au to read the full speech, including Dr Bartone's thoughts on public hospitals, private health insurance and indigenous health, plus a transcript of his Q & A with the Press Club.

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Is it time for the AMA to advocate for patient enrolment?

Last week a woman in her 50s who had last been to our practice about two years previously came in with an interpreter. Her medical record was scant. Her presenting complaint - hair loss. So as I started sorting through the diagnostic algorithm in my head (skin problem, hormonal, autoimmune, nutritional, behavioural, medication), I was also attempting to catch up on all the other issues: screening, updating her health, social, lifestyle, behaviour and family risks. It was becoming a very long consultation. I started running even later.

There weren't any medicines on her record, however, when prompted, she pulled out from her handbag a multitude of various medicines - from antipsychotics to statins. On questioning, the doctor at the other clinic had ordered them. She had also seen her for the hair loss and had blood tests ordered. I reluctantly admit I felt irritated, but also confused as to my role. I suggested that by seeing me she would end up retelling the story, repeating the tests and also not dealing with her many other issues - perhaps many of them intertwined with her hair loss. I wrote a letter to her 'other' GP and suggested she re-present to her.

I'm over doctor shopping (as opposed to doctor choice). It's bad for everyone - the patient, me and the system. It wastes my time, that of the patient and decreases efficiency and accountability on both sides. The evidence is also clear and increasingly overwhelming. Having one GP to care for you is good for your health (even your lifespan), good for the experience of the patient and doctor and good for the system. It therefore meets all aspects of the 'quadruple aim' - health outcomes, patient experience, provider experience and cost.

Until fairly recently the idea of care by a specific general practice being encouraged or supported

by mechanisms such as a specific rebate, grant or differential rebate has been an anathema to many medical and consumer organisations. Perhaps the idea goes against the grain of consumer choice; perhaps people reflect on the inflexible UK models.

However as a GP, I would welcome patient enrolment - to support a relationship of understanding, responsibility and accountability for both me and my patients across the spectrum of care; to be able to better define my patient population and therefore how I perform across care parameters such as screening, immunisation and health outcomes; to get the 'easy and quick' consultations along with the long and tricky ones; for hospitals to have no excuse to avoid communicating with me (such as, "The patient doesn't have a regular GP"); and to underpin a patient-centred medical home. Yes please!

I'd suggest that on the basis of robust evidence across all domains of the quadruple aim we are doing our profession, ourselves and our patients a disservice by not structuring our systems to enable and preferentially support patients seeing a single general practitioner or general practice. Should patients have the ability to choose the most appropriate general practice for

them? Of course. Should they have the ability to change with ease and without detailing their reasons? Of course. Should we develop mechanisms to support a rebate when people are distant from home for reasons such as holiday and work? Of course.

The AMA has always been a strong advocate for our profession and the health of our patients and community through the work of our profession. It has also always been able to change its position based on good evidence. At his recent National Press Club address, AMA Federal President Dr Tony Bartone spoke passionately about the need for the system to reform to strengthen the relationship between the GP and patient. I believe the time has come for one of these reforms to be mechanisms to support patient enrolment to a GP of their choice that is acceptable to both GPs and patients.



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Cancer Council Victoria launches new campaign to educate Victorians about obesity and cancer link



Most Victorian adults (63%) are overweight or obese. There is now strong evidence that recognises that obesity is a risk factor for 13 types of cancer, however, awareness of the link between obesity and cancer remains low among Australians. As a dietician, I want to ensure my patients have the tools for maintaining a healthy lifestyle.

This is why I'm proud to be part of a new campaign being launched by Cancer Council Victoria in October, aiming to educate Victorians about the link between weight gain and certain cancers. The campaign will be shown on TV and radio and will feature across social media channels as well as outdoors.

Sugary drinks are the most significant contributor of added sugar in Australians' diets. There is evidence that a high intake of sugar-sweetened beverages is associated with an increase in body weight and obesity. Therefore the campaign will focus on encouraging Victorians to reduce, or even eliminate, their consumption of sugary drinks. It will utilise resources including meal plans, recipes and fact sheets from Cancer Council Victoria's LiveLighter public health education campaign.

What can GPs do to help?

We know that GPs play a valuable role in helping patients achieve a healthy weight and preventing obesity-related conditions. A recent LiveLighter survey of more than 1000 Australians aged 18-64 found that more than a third of Victorians reported turning to their GP for health and nutrition advice.

The campaign is likely to raise questions among patients about their own cancer risk and what they can do to reduce this. We're encouraging people to talk to their GP if they're worried about their health or need information and support.

We want to make sure GPs feel equipped to answer patients' questions and have the resources and support to provide advice. As part of the campaign, every GP practice in Victoria will receive a support

package providing information about the campaign as well as fact sheets for health professionals and patients. These will provide information about the link between obesity and cancer risk as well as tips for discussing issues raised by the campaign and recommendations about weight management and nutrition.

Key points for discussing obesity and cancer link with patients

- Being overweight or obese increases your risk of 13 types of cancer.
- Visceral fat around our waist and organs is dangerous and can increase your risk of some cancers and other chronic diseases.
- Excess body fat, especially excess "visceral fat" that sits in our middle around our organs, doesn't just sit there and store energy. The fat is active and it produces chemicals and hormones which travel around our bodies and can lead to serious health problems.

Providing advice to patients on weight management can be difficult for

GPs. People tend to see their GP for a specific issue, not to discuss their health more broadly. Cancer Council Victoria's 'Healthy Weight' campaign is designed to get people thinking about what they're putting in their bodies, enabling GPs to have conversations about making healthier choices.

Not sure how to talk to your patients about weight?

LiveLighter delivers workshops for health professionals on providing information and support about weight management to patients as part of routine care. The training is recognised at category one and is accredited by the RACGP. All health professionals are welcome to attend. Remaining workshops for 2018 will be held in Melbourne on Thursday 11 October and Saturday 10 November. To register your interest contact livelighter@cancervic.org.au

Healthy lifestyle recommendations for patients

- If your patient is a healthy weight, encourage them to avoid gaining

weight by following a healthy diet and being physically active.

- Encourage patients who are overweight to follow a healthy diet, do regular exercise and avoid gaining more weight.
- Some patients may find it difficult losing weight, but they can still be motivated to reduce their obesity-related cancer risk by improving their diet and exercising more.

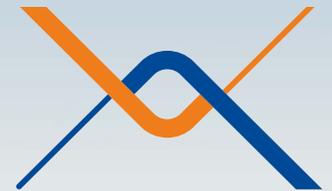
Look out for a Healthy Lifestyle campaign support pack arriving at your GP clinic soon. For more information visit www.livelighter.com.au and find the 'professional development' link in the section for health professionals. For further information about the campaign please contact healthyweight@cancervic.org.au



Alice Bastable
LiveLighter Project Manager
Cancer Council Victoria

References available from the Editor on request.

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Behind the scenes of the EA negotiations



AMA Victoria representatives sign-off on the enterprise agreements.

With the new AMA Victoria Doctors in Training (DiTs) and Specialist Agreements becoming operational on 7 August 2018, it is timely to reflect on the work that goes into the negotiation of these agreements, along with the key changes, and explain the implementation phase.

Doctors will no doubt be aware from previous articles and communications that the negotiation process took a very long time. We started the planning for these agreements in early 2016, more than 12 months before the expiry of the old agreements, when the Workplace Relations team met to plan out the campaign. This plan consisted of three parts: consultation, negotiation and implementation.

The consultation process is the most important part of negotiating a collective agreement. It is vital to the success of the campaign as it is

where the negotiating team hears from members on the changes they would like to see made to their conditions in order to improve their working lives. The log of claims contained more than 60 changes that doctors requested.

Consultation is done in two parts; the first is seeking input from members including, most importantly, the reasons for their requested changes. The second is to seek endorsement for the final log of claims. This is where we get 'sign off' from the membership and we start to prioritise the most important changes. To achieve this,

AMA Victoria ran over 200 consultation meetings through senior staff groups, resident societies, subcommittees and online surveys, as well as individual feedback via email and phone calls.

Once we had established the log of claims, we then sent this to the Victorian Hospitals' Industrial Association (VHIA) in October 2016 with a request to begin bargaining. Unfortunately the VHIA was not ready to start bargaining at that time so we did not start until early 2017. In excess of 60 bargaining meetings took place over the next 11 months, with

many of these meetings attended by doctor representatives who were able to add 'real world' experience to the conversations. These representatives made a significant contribution to the discussions.

The meetings culminated in an offer being made to doctors just before Christmas 2017; but not before there was a series of urgent member meetings to contemplate what action could be taken to get the VHIA and the State Government to speed the negotiations up and put a pay offer to doctors. These meetings endorsed AMA Victoria and ASMOF (Australian Salaried Medical Officers' Federation) investigating the potential for industrial action if this did not happen.

It is important to note that while AMA Victoria was consulting with our members throughout the negotiations, the VHIA was also consulting with its hospitals and that before an offer of settlement was made all health services and the Government agreed to that offer. This means that no clause in the new agreements should come as a surprise to the health services and we expect that all clauses will be fully complied with.

On 15 March this year the agreements were put to doctors to vote and the results were ground breaking for AMA Victoria/ASMOF, with the highest ever percentage of doctors accepting the agreements. Of those who voted:

- 99.75% of DiTs were in favour of the agreement
- 99.3% of specialists were in favour of the agreement.

One of the consequences of so many changes from the previous agreements meant that the Fair Work Commission had much work to do to check that the clauses were compliant with the Fair Work Legislation. As a result, the agreements were not approved until 31 July.

The next phase is implementation and as the agreements are now in force we have commenced a new round of discussions with members and health service management to ascertain how the new entitlements are being approached and where there may be resistance. We are receiving positive feedback from health services on their proactive approach to working through the new elements and we will be communicating the performance of each health service.

One of the key issues being raised by health services is the minimum 10-hour breaks between shifts for DiTs. The clause dealing with this entitlement has not changed; what has changed is the understanding of what the clause actually means by inserting examples. We understand that this is causing some anxiety for management, with the feeling that costs may be higher and that current staffing levels may not support the entitlement. AMA Victoria views the agreed interpretative nuance as important for the health and safety of DiTs and we are committed to working with all stakeholders to ensure it is successful.

The modification that now entitles specialists to devote 20 per cent of their time to non-clinical duties is also causing some similar issues. Again this is a clarification of a term in the

agreement more than a brand new entitlement but we understand that this may require additional resources.

With this in mind, AMA Victoria President, A/Prof Julian Rait, wrote to the Department of Health and Human Services in August and received confirmation that the Government had fully funded the agreements. As a result, AMA Victoria believes there are no impediments to the full implementation of the agreements.

It is our understanding that all health services have now completed the process of passing on pay increases and back pay. If you have concerns that you have not received your correct entitlements please raise this with your health service in the first instance, but if you are not satisfied with the response please contact our Workplace Relations team on (03) 9280 8722 or email amavic@amavic.com.au

For a full list of the changes to the specialists and DiT agreements please visit our website www.amavic.com.au/Enterprise-Agreement.



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General Manager,
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Smart technology saving Victorian lives

Victorian doctors and other health professionals registered with AHPRA are being invited to become GoodSAM responders - supporting our state's emergency response by being ready to provide lifesaving assistance to cardiac arrest patients, while paramedics are on the way.





Keith Young is back enjoying life at home with his family after a cardiac arrest in January, where a GoodSAM responder arrived within minutes.

In January this year, 52 year-old Keith Young was preparing dinner for his family when suddenly he collapsed. His family could never have predicted what would happen next.

“As we worked frantically to save Keith, suddenly a stranger ran in the front door!” said Keith’s partner, Kathryn. “I didn’t know what to make of it. He said he was an off-duty paramedic with GoodSAM and was here to help. He helped us move Keith into the lounge room, where there was more room to work on him. It happened so fast.”

The stranger was off-duty flight paramedic, Darren Murphy. Darren had just signed up with Ambulance Victoria’s pilot of the new GoodSAM app just two weeks earlier. Darren played a key role in supporting the family with CPR, as well as ensuring the scene was ready for paramedics to take over upon arrival. Later he provided support and reassurance by explaining what was going on throughout a chaotic and emotional situation for the family.

Fast forward to today and Keith is doing extremely well, enjoying life with his family and friends and looking forward to getting back to work.

Originating in the UK and now utilised in several locations, including Victoria, GoodSAM is a smartphone app which connects trusted first responders in the community with patients in cardiac arrest. The app is integrated with the Triple Zero (000) dispatch system - when a call is made about a cardiac arrest, an ambulance is dispatched, while at the same time

an alert goes out to the three closest GoodSAM responders.

Responders are first-aid trained as a minimum and verified by Ambulance Victoria or its partner organisations to join the program. Responders download the app and receive alerts when a cardiac arrest is happening up to 400 meters away in built-up areas (or five kilometres in rural areas). If they accept, they are told the location of the patient and, if available, the nearest defibrillator.

“We know that seconds count in a cardiac arrest and the sooner a person can receive CPR and defibrillation, the better the chance of survival,” said Mike Ray, Acting Manager, Emergency Co-Responder Programs at Ambulance Victoria. “For every minute that goes past without this lifesaving support, the chance of survival drops 10%.

“That’s why Ambulance Victoria decided to bring this innovative technology into Victoria. It’s about harnessing the power of the community and connecting trained people with those that need help. GoodSAM essentially gives patients the ability to ‘shout’ through walls and reach trained people that otherwise wouldn’t know they were in trouble. It could even be a neighbour or a friend down the street.”

CPR education and awareness has contributed to more bystanders being proactive when they witness a cardiac arrest event and stepping in to help. Over the last 10 years, bystander intervention in cardiac arrest cases has doubled - and this, along with improved ambulance response times,

has had a direct impact on cardiac arrest outcomes.

In 2016-17, patients who received bystander CPR were around 11 times more likely to be found in a shockable rhythm, the cardiac rhythm most favourable to survival.

Joining GoodSAM as a responder is completely voluntary and the responder has the option to accept or reject any alerts that come their way. “Naturally there are times when a responder won’t be able to accept an alert for a variety of reasons and this shouldn’t cause concern. Alerts are sent to the nearest three responders and an ambulance is always dispatched at the same time,” said Mr Ray.

Off-duty paramedics, fire fighters, surf life savers, coast guards and medical professionals are among the growing community of responders joining GoodSAM. Ambulance Victoria has already established partnerships with the CFA, Life Saving Victoria, St John Ambulance, Australian Volunteer Coast Guard and Chevra Hatzolah, with AHPRA members also able to get on board.

“We really welcome health professionals to join our growing GoodSAM team and help us make a difference to cardiac arrest survival rates in our local communities,” added Mr Ray.

Find out more at www.ambulance.vic.gov.au/goodsam



**Ambulance
Victoria**

In profile: Choosing a speciality



Mr James Keck - Clinical Director of Colorectal Surgery at Eastern Health, Colorectal Surgeon at St Vincent's Melbourne and President of the Colorectal Society of Australia and New Zealand.

Why and how did you choose your speciality?

I had an interest in psychiatry when I started off as a medical student, which changed to cardiology and internal medicine by the time I graduated. It was only when I started work as an intern and resident that it gradually dawned on me that what I loved was the practical nature of surgery. Surgical patients present with problems that are defined, these problems are often treatable or even curable with an operation and most of the time patients go home well and happy. At the same time the whole surgical process is underpinned by the need for expertise in psychiatry and internal medicine, as well as skills in communication, empathy and compassion.

I chose general surgery initially for its breadth of interest and for the emergency work ranging from trauma

to cancer to common inflammatory conditions like appendicitis. Within general surgery I soon found that I was mainly interested in gastro-intestinal structure and function and then I had the opportunity to focus on a single area of sub-specialty interest in colorectal surgery.

Choosing a specialty is one of the most important career decisions for a doctor. Some study medicine with a clear career pathway in mind; others commence with no idea of the direction they might head. In this series we profile a range of specialists who reflect on their careers and selected fields, with the aim of helping others who are still to make a decision.

As a trainee, colorectal surgery was a nascent specialty emerging from general surgery and this process of self-definition as a specialty was fascinating to me. I was working with surgeons who were in the vanguard of establishing our sub-specialty and setting up the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). I still regard these surgeons, including Peter Ryan, Brian Collopy, Roy Fink and Jack Mackay as my mentors and heroes. I am fortunate that they saw some potential in me and gave encouragement and support.

I spent more than five years after my general surgical training doing colorectal surgery including work in Colchester UK, Adelaide, Melbourne and Boston USA for two years at the Lahey Clinic. It was in Boston that I specialised even further with research and clinical expertise in female pelvic floor disorders such as obstetric anal sphincter injury and rectal prolapse.

What personal qualities and skills/strengths do you think are integral to reaching your potential in the role of colorectal surgeon?

Colorectal surgery is technically demanding - operations can be long and exhausting and involve advanced technology such as laparoscopy and robotics. Colorectal surgery is continually evolving so the surgeons need to be curious, agile and committed to ongoing professional development. In my time as a consultant I have had to learn a number of new operations and approaches including laparoscopic bowel resection, sacral nerve stimulation, new operations for fistula and new techniques for colonoscopic polypectomy.

However, as demanding as the technical side of colorectal surgery may be I think the most important qualities a colorectal surgeon needs are personal. Communication skills, especially listening to patients, avoiding cynicism and burn out while remaining empathic, attention to detail and being an advocate and champion for your patient are the real challenges for colorectal surgeons and indeed for all clinicians.

What do you love and what do you find challenging about your role?

I love nearly every aspect of my work if I am honest and feel privileged to do it. I love the way clinical work is ongoing and yet leads to so many other activities that stimulate - teaching surgical trainees, research and international travel, roles in running public hospitals, contribution to health policy and medico-legal opinions. What I find most challenging is dealing with patients who have poor outcomes due to advanced pathology, usually cancer, or who have surgical complications. I find it tiring to work at times and I get stressed when I have too many things to do or to do well.

Describe your typical day as a colorectal specialist.

My day starts with visiting patients in private hospitals followed often

by meetings. I attend public out-patients, supervise surgery in public hospitals or else consult in my rooms or operate in private. I continually check emails on my phone, discarding the dross but trying to respond as soon as possible to important work-related messages. Some evenings I have teleconferences and I spend one or two evenings each week at home at my desk dealing with the running of my office, sending emails, reading work-related documents or papers for review. In the last couple of years I have had fairly frequent trips interstate dealing with official CSSANZ duties or through my involvement with MBS item number reform or trans-vaginal mesh related complications.

Along with my work commitments I play basketball a couple of times a week, I coach representative basketball, I do cryptic crosswords, I read avidly and I listen to music. I go to a concert or movie most weeks and I watch

Hawthorn play football in the AFL. I have at least one holiday each year that involves bushwalking. I don't watch much TV and I make a commitment never to lose my interests outside of medicine and surgery - for example setting aside time to read.

What advice do you have for those doctors considering your speciality?

Look for a mentor or mentors who will provide support and guidance. Look for a department or unit where you would like to work and then make yourself an indispensable part of that department. Do some research (training is unachievable these days without it), show you can work hard and remain cheerful and continue to nurture the parts of your life that make you an individual worthy to work alongside, including family, friends, sport and exercise and cultural interests.

We would love to hear from you if you want to share your story about choosing a speciality, or if you would like assistance in navigating your career path. Please contact our Careers Consultant Carolyn Speed on CarolynS@amavic.com.au

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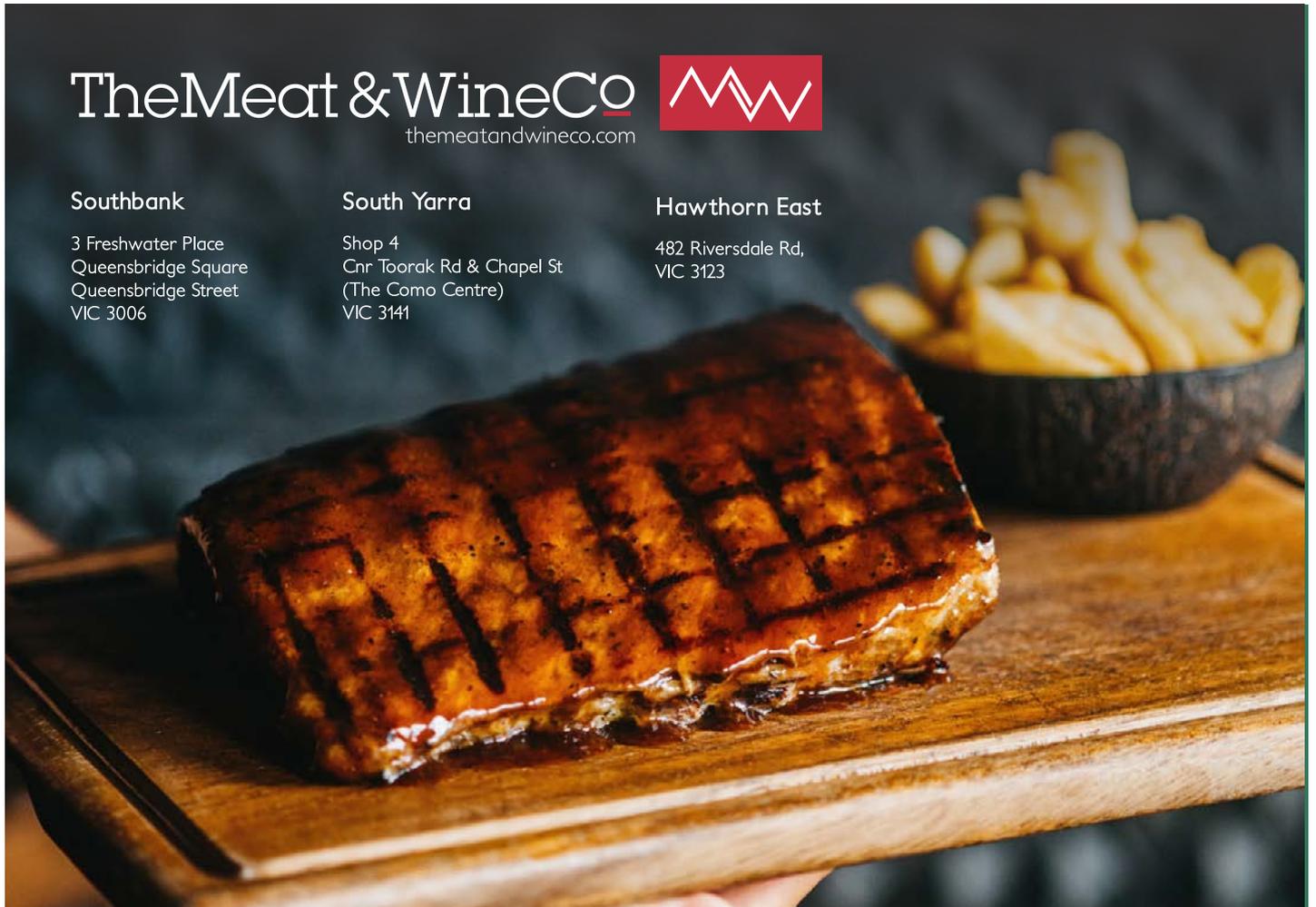
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VIC 3123



Sharing stories from different eras



Dr Anna Power visits Dr John Floyd every fortnight through our Peer Visitor Program.

AMA Victoria Peer Visitor Program - Dr John Floyd and Dr Anna Power

Every two weeks, Dr Anna Power, a third-year hospital medical officer (HMO), takes a break from her full-time studies towards a Master of Public Health plus her work as a locum HMO to visit Dr John Floyd, a retired ENT surgeon aged 96. Anna has been volunteering with the Peer Visitor Program since her final year at medical school and has been visiting John for eight months.

John, who was born in 1922, started studying medicine at Melbourne University in 1939 alongside about 140 students. This dropped to about 90 students in second-year. First year studies covered broad sciences and only in second-year did students begin specific subjects for their medical degree. He recalls that medical students were not allowed to enlist for the armed services during World War 2, however, some students deliberately failed so they could join the army. During John's time at university the length of the medical degree was reduced to five years, so he sat his finals at the end of 1943 and graduated early the following year before completing his internship. In his early years of practise John remembers the introduction of penicillin and what a difference this made to the treatment of infection.

John joined the RAAF as a medical officer in 1945 and spent time in the

Dutch East Indies (now Indonesia) on the Morotai Island, which sits right on the equator. He recalls that this was a busy location with many Australian and American troops passing through after the end of World War 2 as they were sent to occupy Japan and other locations in the Pacific which had been held by the Japanese prior to the surrender. John remained in the RAAF for five years including one year of service on his return to Australia. After leaving the air force he worked as a resident doctor at Geelong Hospital for 18 months and then as a locum. John initially planned to become a GP and while preparing for this he was working at the Royal Women's Hospital when he met his future wife Linda, a nursing sister in the labour ward. They remain married and living together in an aged care facility a short walk from their family home.

John subsequently decided to specialise in the area of ENT surgery and undertook a residency at the Royal Victorian Eye and Ear Hospital (RVEEH) for two years while undertaking his post-graduate degree. When his studies were completed, an established ENT colleague invited John to share his rooms at 81 Collins Street in the CBD. John recalls that at this time about 90 per cent of all specialists had rooms in the 'top end' of Collins Street. He began with one day per

week in the private rooms plus hospital appointments, but when his colleague died unexpectedly he suddenly had a very large workload. A few years later the son of his former colleague, who had been studying medicine at the time of his father's death, joined John in the practice and they shared the rooms for over 20 years.

The retired surgeon recounts that public hospital appointments such as those he held at the RVEEH, the Royal Melbourne Hospital and the Royal Children's Hospital (RCH) were honorary and without remuneration. However, the RCH provided surgeons with private operating time. He remembers treating private patients at the Epworth Hospital, Bethesda Hospital and Vimy House. John ultimately specialised as a paediatric ENT surgeon and says his most common procedure was tonsillectomy. In addition, John saw many children with middle ear infection and prior to the introduction of grommets during the 1950s, glue ear was a significant cause of hearing loss and delayed speech in children. He also recalls the spread of middle ear infections to mastoiditis and potentially meningitis and remembers from his school days seeing boys returning to school with large scars behind their ears after treatment of mastoiditis. Over his lifetime, John believes that the ENT procedure which has made the most difference was the stapedectomy

to treat otosclerosis which resulted in conductive hearing loss.

John was active in the Otolaryngology Society and is a life member of AMA Victoria. He retired from his private practice when he was in his mid-50s but continued to work with deaf children and the education department until he was in his early 70s. He has been retired for over 20 years.

Dr Anna Power comes from a medical family, with her mother a geriatrician, a sister who is also a HMO and another who is currently studying medicine. Anna plans to undertake conjoint training in general practice and public health and is planning a career combining the two with a focus on preventative health. She has an interest in refugee health and is also a volunteer with the Water Well Project, which aims to improve the health and wellbeing of refugees and asylum seekers by improving their health literacy. Medicine combines Anna's interest in science, especially biology, and people.

John was always interested in science and had a grandfather and an uncle who were GPs in the United Kingdom. He began reading medical journals

as a boy. These journals were sent inadvertently to his father who had a PhD in music and so was 'Dr Floyd'. John says that he enjoys the opportunity to keep in touch with medicine through Anna's visits as he has outlived all his friends and his twin sons chose other career pathways. Medicine has been such a big part of his life, he appreciates the opportunity to stay connected through the Peer Visitor Program.

Anna says she finds it really interesting to listen to John's stories about medicine and reflects that although they have had very different journeys they do share similarities and a common interest in all things medical. Prior to visiting John, Anna visited Dr Margaret Henderson who passed away at 102 years of age in August 2017.

The AMA Victoria Peer Visitor Program is open to any older doctor who would like a visitor. All volunteers are members of AMA Victoria and range from medical students, doctors at varying stages of their career and retired medical professionals.

The visits to Dr John Floyd are facilitated through the Community

Visitors Scheme (CVS) which is coordinated by the MS Society of Australia. Most aged care facilities throughout Victoria are linked to the CVS under the auspices of a range of program providers across the state. Our Peer Visitor Program can also facilitate visits in private homes.

For more information about the Peer Visitor Program visit www.amavic.com.au/assistance-for-doctors/Support-Programs/peer-visitor-program or email Kay Dunkley on KayD@amavic.com.au



Kay Dunkley
Doctor Wellbeing and Mentoring Advisor

The AMA Victoria Peer Visitor Program is proudly supported by PSA Insurance.



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Changing Lives.

Fit to drive? Recent Coroner's cases highlight ongoing challenges

Five recent coroner's cases highlight assessing fitness to drive challenges including balancing patient personal independence with road safety. A/Prof Morris Odell from the Victorian Institute of Forensic Medicine reflects on how we can use the VicRoads medical review system to achieve this balance and help patients meet their reporting obligations.

The circumstances surrounding fatal road crashes make for sombre reading, with tragic impacts for families and loved ones. Our reactions to such incidents are understandable, particularly if the at-fault driver is found to be medically impaired.

Responding to five separate incidents in the last 22 months, the Victorian Coroner has concluded that the current self-report notification system (which applies to all Victorian drivers with long-term health conditions that may impair driving) is not meeting community expectations. All five reports recommend strengthening legal obligations via the introduction of mandatory medical reporting for health professionals to report unfit drivers. At the time of writing, this had not been adopted by the State Government.

In each of the five cases, the impaired driver/rider was not known to the VicRoads medical review system. The driver/rider had not notified the licensing authority of their chronic medical condition as required under the *Road Safety Act*. Additionally, it was apparent that some drivers had continued driving despite medical advice to the contrary and in some cases health professionals had knowledge of their patient's continued driving and did not notify VicRoads directly.

So, what are these cases telling us about the current medical review process and our engagement with it?

Health professional roles, responsibilities and opportunities

The primary aim of assessing fitness to drive is to assist drivers with long-term health conditions to continue to drive safely and legally, and to identify when driver and public safety may be compromised. While it is true that all drivers have a legal responsibility to report to VicRoads so that the medical review process can be initiated, drivers rely heavily on advice provided by health professionals about how medical conditions and treatments might affect their safe driving ability and their notification obligations to VicRoads.

In a case involving an elderly driver with dementia, whose wife was killed in the incident, the Coroner observed there was no evidence that fitness to drive was discussed by the driver's treating health professionals, despite documentation of his long-standing significant cognitive impairment.

Routine empathetic discussion about driving is integral to the management of progressive conditions such as dementia, where the transition to non-driving is inevitable and is ideally planned and managed through conditional licensing and regular review, including practical driver assessments. All these licensing interventions are facilitated through the medical review system.

Discussions about driving need not be the sole responsibility of the health practitioner. Practice staff can integrate conversations about driving into chronic disease management, thus supporting informed patient and family decision-making and engagement. Opportunistic proactive discussion about fitness to drive can also arise during periodic general assessments such as the 75 and over health check.

New resources available through the VicRoads website aim to support conversations with patients about driving.

Understanding the VicRoads medical review and licensing processes

There are common misunderstandings about the medical review process and licensing outcomes that may contribute to lack of engagement by health professionals and drivers. Most importantly, having a medical condition does not mean a person is ineligible to hold a licence. In most cases, a VicRoads medical review assessment does not result in licence cancellation.

Returning to our dementia example, the national fitness to drive guidelines (*Assessing Fitness to Drive 2016*) take into consideration the progressive nature of dementia and the need for supported regular monitoring from early on, after diagnosis. Drivers with a diagnosis of dementia are not eligible for an unconditional licence and are required to notify VicRoads so they can come under the medical review process. However, they may be eligible for a conditional licence, linked to a requirement for regular monitoring, which allows them to drive for as long as they are safe to do so, in conditions commensurate with their capacity (such as within a familiar local area with a radius-restricted driving area). Regular reviews are prompted by VicRoads, evidence of fitness to drive is considered on a case-by-case basis and additional assessments advised as required, with VicRoads making all final licensing decisions.

Overview of the medical review process: Case-by-case assessment and decision making by VicRoads



Notifications to VicRoads Medical Review

VicRoads legally obligated to investigate all notifications

Assessments required

- > For ALL drivers: Medical Report (GP)
- > If required:
 - Specialist Medical Report
 - Eyesight Report
 - Occupational Therapy Driving Assessment
 - Medical Review Driver test
 - Expert analysis - external medical advisors

Licensing decisions made by VicRoads

- Licence without conditions
- Licence varied with conditions (eg. area restrictions, vehicle modifications, spectacle condition, no night driving)
- Licence suspended or cancelled
- Options for retest/further driving lessons
- Periodical medical review (as guided by AFTD)

Awareness of tools and practical driver assessments

Many doctors are not aware of the tools and assessments that can support their decision-making and management of patients with respect to fitness to drive. The *Assessing Fitness to Drive 2016 Guidelines* describe the criteria and tools for establishing fitness to drive status for common conditions known to pose road crash risks. The guidelines explain that on-road assessments offer high face validity, provide information about functional driving skills that can supplement the medical review assessment and help to clarify concerns raised by family, particularly when the patient presents with cognitive and/or multiple morbidities. They are also helpful for drivers with physical impairments who may benefit from driver rehabilitation and vehicle modifications.

The new VicRoads webpage for health professionals connects you to tools and resources to support you

in assessing and managing fitness to drive for your patients. Visit www.vicroads.vic.gov.au/licences/health-and-driving/information-for-health-professionals

Awareness of legal obligations and protections

When it comes to making reports about fitness to drive, health professionals are understandably concerned about patient confidentiality and their own liability. Commonly, they are unclear about what they should do if they know or suspect that a patient is still driving, despite being advised not to. On the question of liability, it is not expected that medical assessments of fitness to drive will prevent all crashes. To our knowledge, no Australian doctor has faced criminal charges over certifying fitness to drive inappropriately, but there have been cases where doctors have been disciplined by the Medical Board as a result of these opinions.

While there is currently no mandatory reporting requirement for health professionals in Victoria, there is an ethical obligation for health professionals to support public safety. Therefore, if you believe a patient lacks insight/judgement, or is not heeding advice to cease driving or self-report, you may report directly to VicRoads. You may choose to do so anonymously if you wish. If you believe the driver poses an immediate risk to public safety, you should report directly to the police. Road safety legislation provides indemnity for health professionals making such reports.

Legal and ethical obligations for health professionals are outlined in *Assessing Fitness to Drive* - visit www.austroads.com.au



A/Prof Morris Odell
Head, Clinical Forensic Medicine Services
Victorian Institute of Forensic Medicine

- Our patients rely on us to provide advice about the impacts of medical conditions on driving and to make recommendations for management and monitoring.
- The VicRoads medical review process provides a mechanism for assessment and decision-making about licensing, and for facilitating ongoing review if required. In doing so it aims to optimise driver mobility and capacity to drive for as long as they are safe to do so in conditions that suit their capabilities.
- All drivers have a legal responsibility to self-notify VicRoads of significant long-term health conditions or disabilities that may affect driving safety. Health professionals can assist patients to be aware of this responsibility and to understand the medical review process.
- Having a medical condition does not mean a person is ineligible to hold a licence and in most cases, VicRoads medical review does not result in licence cancellation. It may result in driving restrictions or medical monitoring to ensure ongoing fitness to drive.
- While health professionals are not legally mandated to notify directly to VicRoads, they are ethically obliged to act in the interests of public safety if they are aware a patient is continuing to drive despite advice to the contrary. Health professionals making such reports to VicRoads are indemnified under Victorian Road Safety law.
- A new web page dedicated to fitness to drive for health professionals is now available on the VicRoads website.

KEY POINTS

Changes to notifiable conditions in Victoria: What you need to know

Medical practitioners and pathology services play a vital role in protecting public health by notifying cases of specific infectious diseases and other conditions to the Department of Health and Human Services (DHHS).

This provides a crucial early warning of a potential threat to public health and enables the department to respond to prevent or control the spread of disease. It also provides data on significant diseases in Victoria, allowing for the identification of emerging trends and the implementation of appropriate policy responses and public health interventions.

The *Victorian Public Health and Wellbeing Act 2008* sets out the requirements for both medical practitioners and pathology services to notify the department of cases of specific infectious diseases and other medical conditions. Following consultation with medical practitioners, pathology services, infectious disease experts and other key stakeholders, changes have been made to the specific infectious diseases and medical conditions that must be notified to DHHS and how they must be notified.

The *Public Health and Wellbeing Regulations 2009* which set out the requirements for both medical practitioners and pathology services to notify the department of specific conditions were changed to:

- reduce the number of conditions that must be notified by medical practitioners
- simplify the groupings of notifiable conditions
- reduce the requirement to notify in writing
- reprioritise notifications for some conditions.

These amended regulations came into effect on 1 September 2018. Here is everything you need to know about the new changes.

What has changed?

Ten conditions no longer need to be notified by medical practitioners.

Medical practitioners are no longer required to notify the department of cases of the following 10 conditions:

- Barmah Forest virus infection
- Ross River virus infection
- Arbovirus (other)
- Chlamydia trachomatis infection
- Influenza
- Campylobacteriosis
- Leptospirosis
- Psittacosis
- Blood lead >5→g/dL
- Hepatitis viral (other/not specified).

Pathology services continue to notify the department of these conditions and these notifications provide the required case information for the department's public health response.

Simplified grouping of notifiable conditions from four to two groups

The groupings of the notifiable conditions have also been simplified.



Previously, notifiable conditions have been organised into four groups (A, B, C and D), but are now condensed to two groups - 'urgent' and 'routine'.

- 'Urgent' conditions (formerly Group A conditions) require immediate telephone notification.
- 'Routine' conditions (formerly Group B, C and D conditions) require written notification within five days. Routine conditions include sexually transmitted infections and HIV, but these conditions will continue to be notified in a manner that does not disclose the identity of the case.

Reduced requirement to notify in writing

While medical practitioners are still required to notify the department immediately by telephone where a specified urgent condition is suspected, the requirement to follow-up that notification in writing is no longer necessary. These changes help reduce the notification workload for medical



practitioners, allowing them to focus on a reduced list of priority conditions. Pathology services are still required to follow up urgent notifications in writing within five days by sending the laboratory results, as per established processes.

Re-prioritisation of some conditions

Rotavirus has been added to the 'routine' group of conditions for pathology services (but not medical practitioners). Rotavirus has not previously been notifiable in Victoria. It is the most common cause of severe diarrhoea in young children worldwide and is vaccine-preventable. Notification of rotavirus cases by pathology services in Victoria is important as it enables close surveillance and better understanding of the disease burden and effectiveness of the immunisation program.

Chikungunya virus infection has been reclassified from urgent to routine, reflecting the risk posed by this condition in Victoria. As a routine notifiable condition it must be notified to the department in writing within five

days by both medical practitioners and pathology services.

Listeriosis notification has been upgraded from routine to urgent to reflect the public health significance of the disease. Reclassifying this condition ensures that the details of any suspected or confirmed cases are immediately notified to the department by both medical practitioners and pathology services, allowing them to be investigated as a matter of priority.

AIDS has been removed from the notifiable condition list, in line with the national notifiable disease list. The requirement for both medical practitioners and pathology services to notify the department of cases of HIV infection remains.

Why notify?

It's essential for public health and it's protected by law.

Beyond the formal list of notifiable conditions, the *Public Health and Wellbeing Act 2008* provides a general

authority for medical practitioners and pathology services to provide the department with any case information that relates to a potential public health risk.

People providing this information are protected from claims of unprofessional conduct and it does not contravene any other legislation. The department encourages medical practitioners and pathology services to pass on the details of any perceived risk to public health, even if it is not currently listed in the regulations. This allows the department to be better informed about public health incidents and trends and take appropriate responses to emerging threats.

Further information on notifiable conditions can be found at: www.health.vic.gov.au/notify



Prof Charles Guest

Chief Health Officer
Department of Health & Human Services



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Military surgeon calls for new terrorist attack treatment measures



Leading military surgeon, Professor Jeffrey Rosenfeld says Australian hospitals should become familiar with US military trauma guidelines to better prepare them for terrorist attacks or other mass casualty events.

A senior neurosurgeon at The Alfred Hospital, Professor of Surgery at Monash University and a Major General in the Australian Defence Force, Prof Rosenfeld is also calling for civilians to be trained in haemorrhage control through the 'HemCon' course developed by the American College of Surgeons and the Hartford Consensus in the US. These recommendations were made

after a US school shooting in late 2012 in which 20 children were fatally shot.

Prof Rosenfeld was elaborating on comments made in a paper recently published in *Emergency Medicine Australasia*, co-written with Alfred trauma specialists including Professors Mark Fitzgerald and Biswadev Mitra, and senior Australian military medical specialists and leaders in ambulance services.

Prof Rosenfeld, who has been deployed as a military surgeon in Iraq and other war zones, said the type of trauma that occurs in war zones and terrorist events is very different from the blunt trauma seen in hospital emergency departments.

"Bomb blast injuries cause a lot of internal damage to the organs and various structures in the body," he said. "If you're close to the blast you've got penetrating injury where metal, foreign material like concrete, dirt or clothing go in all different directions through internal parts of the body. Then there are hot air blasts and burns, and injuries to lungs which may make it difficult to ventilate a patient. "We can't assume that people working in hospitals know about all of this."

Prof Rosenfeld said the US military had made major improvements in trauma care in the past 15 years through lessons learnt in Iraq and Afghanistan. He would like its Tactical Combat Casualty Care Guidelines adapted for use in Australia.

"The highest survival rates of all military hospitals in history were achieved by using these protocols," he said. "We don't need to reinvent the wheel."

All Australian states now have comprehensive emergency plans with pre-hospital services and emergency departments at high levels of readiness for disaster response and mass casualties, the paper said. These events include bushfires, such as the deadly Black Saturday fires in 2009, and the thunderstorm asthma epidemic

in November 2016. "We have various trauma protocols in Australian hospitals and separate disaster protocols but we need more consideration of the management of blast injury and penetrating ballistic trauma."

Few bomb blast attacks have occurred in Australia to date, nevertheless the country is now on a 'moderate' terrorist threat watch and health professionals need to be prepared to treat mass casualties with blast and ballistic trauma according to military principles, according to Prof Rosenfeld.

Training could include also burns management and the decontamination and treatment of chemical weapons victims. Prof Rosenfeld said tourniquets and combat gauze designed to stop life-threatening haemorrhages used by the US military should be made available to first responders including ambulance paramedics, volunteer firefighters, the public and in lifesaving clubs for shark attack injuries. "Bleeding to death is one of the big killers in critical situations."

He recommends information about how to use the tourniquets should be introduced to first aid training courses such as St John's Ambulance and inexpensive kits containing them placed in the same areas as defibrillators. "These are very simple, very inexpensive measures. Once you roll them out and educate people you will save a lot of lives," Prof Rosenfeld said.



Anne Crawford
Monash University



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This article was first published on www.monash.edu

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Movement as medicine helps at-risk Aussies

GPs and other health professionals are perfectly placed to work with patients to improve their health through physical activity, according to the Heart Foundation. A recently published research paper on exercise as an essential evidence-based medicine suggests physicians should offer physically inactive patients brief advice, including a written exercise prescription.

Co-authored by Dr Anita Green, who was the Chief Medical Officer for the Gold Coast 2018 Commonwealth Games, it says patient goals need to be specific and their progress followed on a regular basis. The paper recommends that physicians apply a '5As' approach: Ask, Assess, Advise, Assist and Arrange.

Heart Foundation Chief Medical Advisor Professor Garry Jennings said the research paper highlighted the vital role GPs and other health professionals could play in helping Australians understand and reap the health benefits of physical activity.

"Health professionals meet many patients who are not physically active enough, and are perfectly placed to start a conversation about how 30-60 minutes of physical activity each day is required to improve or maintain good health or to manage chronic conditions," Prof Jennings said.

"Most Australians don't know that physical activity is the easiest thing you can do to improve your health, and that it doesn't have to involve going to the gym or undertaking intensive exercise."

Going for a daily walk of at least 30 minutes can reduce a person's risk of heart disease by 35 per cent, and can help manage high blood pressure, high blood cholesterol, and overweight and obesity. It also reduces a person's risk of type 2 diabetes by 30 per cent, and reduces the risk of several cancers (including bowel, breast, kidney, lung and stomach cancer). Being active also has important mental health and cognitive benefits including lowering risk of depression, anxiety, and dementia.

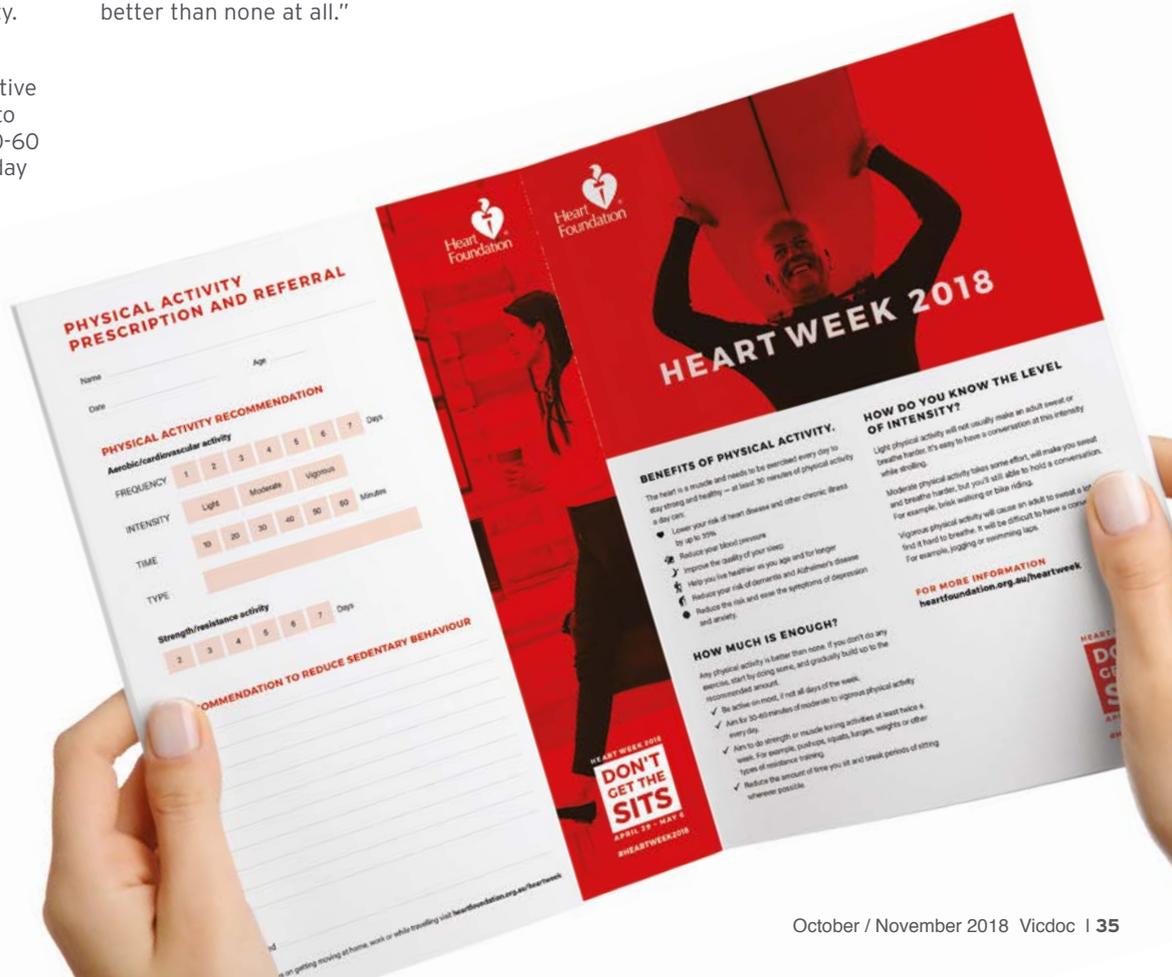
Professor Jennings made the point that all exercise is good, even if it's below guideline recommendations. "It's great if you're doing the recommended 150 minutes per week. But people shouldn't be put off if they are just starting, and for now they find that too much. Any physical activity is better than none at all."

The Heart Foundation has a range of resources available, including a physical activity prescription pad that can help GPs discuss the topic with patients and "prescribe" a level of activity that suits the individual and their circumstances.

For more advice on how to help advise patients on physical activity, you can download a toolkit that includes a physical activity 'prescription pad', from www.heartfoundation.org.au/heartweek. You can also call the Heart Foundation Helpline on 13 11 12.



References available from the Editor on request.



Event wrap: Family planning and balancing medicine seminar

The room was full of current and future parents, warming up on party pies on a chilly August evening after a full day of work or study. The topic was one not commonly discussed in the workplace - identifying the right time to have a family and how to balance this with a medical career.



AMA Victoria's industrial relations advisor, John Ryan, described the impact of workplace culture and the difference between workplace rights and workplace realities in relation to family friendly environments. He provided an overview of parental leave provisions in a variety of settings, including the new provisions in the enterprise agreement for hospital medical officers.

John also warned that as a pregnancy may not always go according to plan it is essential to consider if lighter or alternate duties may be required and the need to use other leave provisions for medical appointments or unexpected health issues. He noted that there may be times when both parents need to take leave and that parental responsibility usually continues for at least 18 years, until a child finishes secondary education. John advised all those planning a family to seek expert advice from AMA Victoria about their individual circumstances, before concluding with a reminder that membership can continue during parental leave with a special discounted rate for members who are not working or in a part-time role.

Obstetrician Dr Amber Moore gave an engaging presentation about issues

including how both partners should prepare for pregnancy and which pre-pregnancy and prenatal tests should be undertaken. She outlined declining fertility and fecundity for women in their 30s and talked about options such as freezing eggs, IVF and surrogacy. Amber, who is a mother to four children, also described in a very entertaining manner her own experiences juggling parenthood and medicine, how to minimise stress through outsourcing and how this can enrich your life through expanded support networks. Some of her stories were very poignant and included experiencing a pregnancy loss while simultaneously assisting with a caesarean section.

A generous panel of Dr Tara Purcell, Dr Phuong Pham and Dr Sue English then described their own personal experiences as medical parents. Tara noted that she started her family while studying medicine and how essential her support network, including other parents, is to maintain a balance. Phuong described the detailed consideration she gave to approaching parenting differently from her own medical parents, by choosing to stay home and defer training with a view to returning to training and work part-time when her partner has completed

his training. Sue described balancing full-time work as a practice-owning GP practising obstetrics - which required the occasional need to take her young boys into the labour ward - plus the value of a beloved nanny in her household. With the wisdom of hindsight, now that her children are young adults, Sue was also able to talk about the light at the end of the tunnel, as she now works part-time and pursues international charity work in East Timor and mentoring, among a broad range of other interests.

The key messages from the night were:

- The right time to have a family is... when it's the right time for you (not everyone else)!
- Build a village - have a support network to help you.
- It's ok to be out of control - life isn't perfect.
- Look after yourself - physically and mentally.
- AMA Victoria can help you - just ask us! Our workplace relations team is only a phone call away on (03) 9280 8722.

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What work's really like for a bush GP

Being a GP in a remote outback location is rewarding work – but it's not necessarily for the faint-hearted. You're likely to be the only doctor there and if things go wrong, help may be some time coming.

"You're by yourself, you're thrown in the deep end and you've got to manage that," said Dr Chris Clohesy, who has spent the last five years working as a GP in remote communities in Northern Territory, after a 20-year career in the city. "There's the constant threat that something will come up that takes you to the limit and there's no one holding your hand. You're asking yourself: am I up to it?"

Dr Clohesy recounted a time when he had to manage a child who had drunk petrol and was fitting. "I was in a remote community and there was only me and a couple of nurses. We didn't have much equipment and we were talking to Darwin by phone, with a plane a good couple of hours away. This one had a good outcome, but you remember these things. They're frightening and challenging situations."

Then there are the more quirky episodes that a doctor is never going to experience in a suburban Melbourne clinic – such as the occasional veterinary intervention, for example. "Late one day a chap brought in his dog, which had been run over and had a massive abdominal wound, extending from the groin to the belly. 'Can you do anything?', the owner asked. So we sewed the dog up and gave it some antibiotics and incredibly, the dog survived. I couldn't believe it! So you do have to think out of the square and handle some weird cases."

The key to working remotely, Dr Clohesy believes, is to keep your skills and knowledge up to scratch. "It's a difficult process finding the educational resources to be able to upskill. I spend a lot of time hunting down courses and clinical attachments to keep me up to date. And it's a lot of time and money. Rural and remote doctors have the same educational requirements as

everyone else, but it's a lot harder to get them. And for junior registrars studying for exams it's really hard, particularly if you have a dodgy internet connection!"

Online learning definitely has a big role to play for rural and remote doctors, Dr Clohesy said. "But it's got to be good. You can't just put something up on the internet and say, there you go. There's still got to be some sort of human contact with that online course where you can actually talk to someone and an expert you can contact really enhances the course."

Dr Clohesy recently flew to Melbourne to do an Advanced Life Support course. He paid his own airfare, plus the \$700 for the course, with the whole trip taking three days. "That's so I'm up to speed on the cardiac stuff I need to deal with out here. It's not about sitting about under a palm tree on the beach; it's a serious challenge."

It's also important to keep your outside interests and lifestyle ticking over, according to Dr Clohesy, whether it's sport, exercise, fishing or reading. "At the moment I'm getting my bikes and gym equipment shipped to me by barge from Darwin. Luckily, where I am has a swimming pool, so I can do my laps which is important to me."

Keeping in the medical loop and maintaining your networks is also important when you're working in remote locations. "I belong to the AMA, I join as many committees as possible and all that improves my interactions with other doctors."

The job definitely has its own rewards, Dr Clohesy said. "Most doctors are out here because they want to help and they want to look after these impoverished people and that gives them a huge amount of satisfaction."

Junior doctors may think if they go rural they'll miss out on positions in metropolitan hospitals, but that's not always the case. "These days, as a junior doctor, it's really positive to have a CV with some rural work on it. It shows you can work independently," Dr Clohesy said. And there are various incentives, such as the General Practice Rural Incentives Program, which pays doctors an annual amount for working in rural and remote areas, with the amount rising with each extra year of service.

"We have a public health role. I think it would be great if all doctors did a six-month stint in a rural or remote community. We'd overcome a lot of deficiencies if that happened."

- Are you working in a remote or rural community? Doctorportal Learning has a number of online learning modules that may suit your certification needs – learning.doctorportal.com.au/catalogue
- Our Cranaplus Advanced Life Support module can be completed entirely remotely, with an online theory component and a clinical assessment using Skype. This module is the only accredited ALS in Australia that enables you to undertake the clinical assessment via a virtual platform.



Editor's note: AMA Victoria will be strongly advocating in regional and rural areas in the lead-up to the Victorian state election on 24 November.

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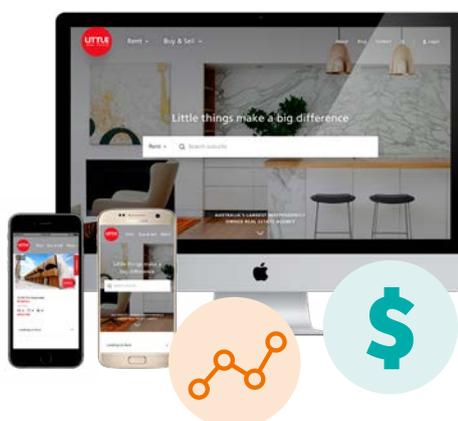
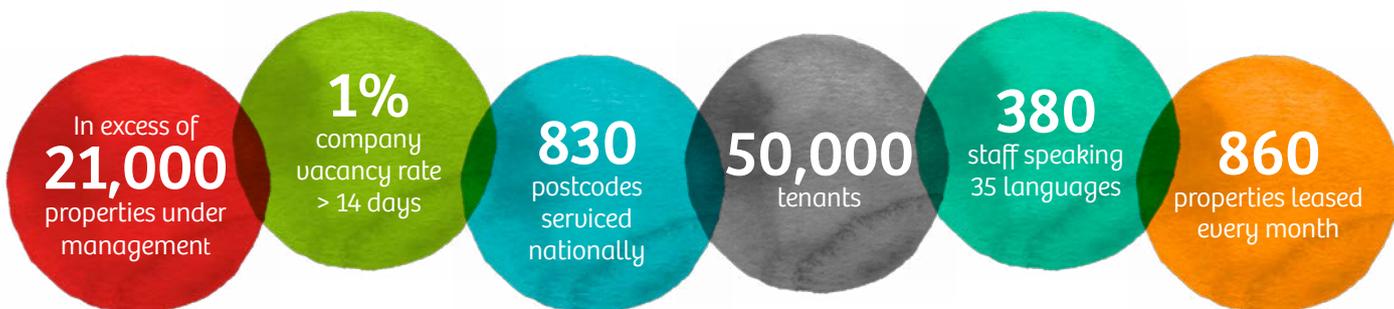
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Healthy parents, healthy baby: The benefits of optimising preconception health

It has long been known that epigenetic changes occur in fetal life in response to the environment in the uterus. For example, if a pregnant woman smokes or is undernourished, this increases the risk of the baby being smaller than expected at birth (small for gestational age). This in turn increases the child's risk of non-communicable diseases including cardiovascular and metabolic conditions in adulthood.



Parents' preconception health affects fertility and the health of babies

There is now growing evidence that the health of both parents before and at the time of conception influences the chance of conceiving and the short and long-term health of offspring. This is because the environment where eggs and sperm mature and the composition of the fluid in the fallopian tube when fertilisation takes place are affected by parents' general health. So, in addition to the genetic material parents contribute to their offspring, their condition at the time of egg and sperm maturation and conception have lasting effects on the expression of the genes and the health of the future child.

Obesity, smoking, environmental toxins, alcohol, drugs, lack of physical activity and poor nutrition all pose risks to the health of egg and sperm and consequently to the health of a future child. Chronic health

conditions such as diabetes and hypertension can also adversely affect gamete health.

Why promoting preconception health in primary healthcare is important

Whether they are actively trying for a baby or not, people of reproductive age can potentially conceive any time. This is why preconception health messages need to be integrated into primary healthcare and discussed opportunistically with women and men of reproductive age whenever possible.

Screening for pregnancy intention

A condition for preconception health optimisation is that the pregnancy is planned. To reduce the risk of unintended pregnancy, the RACGP's *Guidelines for preventive activities in general practice* recommend screening for pregnancy intention in primary



healthcare settings. A promising idea for assessing the risk of unintended pregnancy and giving prospective parents the opportunity to optimise their preconception health is the One Key Question® (OKQ) initiative developed by the Oregon Foundation for Reproductive Health. It proposes that women are asked, “Would you like to become pregnant in the next year?” as a routine part of primary healthcare to identify the reproductive health services they need to either avoid pregnancy or increase the chances of a successful one. This non-judgemental approach allows practitioners to provide advice about reliable contraception if the answer is ‘no’ and information about preconception health if the answer is ‘yes’ or ‘maybe’.

Providing preconception health information and care

While a 15-minute consultation will not allow in-depth discussions about contraception or preconception health, directing women to reliable sources of information and inviting them to make a time to come back to discuss their

reproductive health needs in light of their pregnancy intentions might increase awareness of the importance of preconception health optimisation.

Considering the mounting evidence about the role of paternal preconception health for fertility and the health of offspring, men also need to be made aware of the importance of being in the best possible shape in preparation for fatherhood. Directing men to accessible and reliable sources of information about male reproductive health can improve awareness about how they can contribute to the long-term health of their children.

Helpful resources

Your Fertility is a government-funded national fertility health promotion program to improve awareness among people of reproductive age and health and education professionals about potentially modifiable factors that affect fertility and reproductive outcomes. The program’s main platform for dissemination of

information and engagement is the website www.yourfertility.org.au. Time-poor practitioners can direct their patients to this website knowing that it offers evidence-based, up-to-date, accessible information about all aspects of female and male reproductive health in a range of formats. It also has helpful resources for health professionals, including short videos, webinars and fact sheets to help you promote the important messages about how healthy parents make healthy babies.

A helpful preconception care checklist for practitioners can be found at www.racgp.org.au/AJGP/2018/July/Preconception-care



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References available from the Editor on request.

Healthcare industry out in front on data breaches

Two recent reports suggest that the healthcare industry suffers more data breaches than other industries and that these data breaches tend to be more costly.

Privacy Commissioner Quarterly Report

The Office of the Information Commissioner (OAIC) recently released its quarterly report on data breaches notified under the *Privacy Act 1988*. The report showed that healthcare is Australia's leading sector for notifiable personal data breaches.

More than 20 per cent of the 242 data breaches reported to OAIC in the quarter ending 30 June were suffered by health service providers. No other industry sector accounted for more than 15 per cent of breaches. The most common cause of breaches occurring in the healthcare industry was human error. Twenty-nine of the 49 breaches reported were attributable to human error and 20 to malicious or criminal attack. Interestingly, the healthcare industry was the only sector for which human error caused a majority of notifiable breaches - in all other industries, malicious or criminal attack was the leading cause.

The report also offers a breakdown of the types of human error which caused the data breaches in the healthcare industry. The most common were:

- sending personal data to the wrong recipient (particularly by email)
- insecure disposal of records
- loss of paper records or data storage devices
- unintended publication of data.

Of the breaches attributable to malicious or criminal attack, the most common types were:

- theft of records or data storage devices
- cyber attacks
- deliberate action by a rogue employee.

The cyber attacks on the healthcare industry mostly involved lost or stolen credentials (such as phishing or brute force attacks). According to the data, most breaches in the healthcare industry tend to be small scale - 22 per cent of those reported affected only a single person, and 69 per cent affected fewer than 100 people.

Ponemon Institute Study

The 2018 Ponemon Institute Cost of Data Breach Study also makes sobering reading for the healthcare industry. The Institute's annual survey collected details on data breaches from 477 organisations in Australia and across the world.

The study found that the average data breach costs healthcare providers an average of \$567 per affected individual. This was more than two and a half times the average cost per individual across all industries (\$205). No other industry came close to the health industry in this statistic - a data breach in the second most expensive industry, financial services, cost an average of \$286 per record. This appears to be consistent with the OAIC's finding that healthcare data breaches tend to be on the smaller scale - it stands to reason that a breach affecting 1,000 individuals will cost less per capita than a breach involving one or two individuals.

The health industry also led in churn rates - a measure of how many customers an organisation lost after a data breach. Health service providers reported losing 6.7 per cent of their customer base following a data breach, almost double the overall average of 3.4 per cent.

Conclusion

The data suggests that not only do healthcare providers suffer more data breaches than any other industry, but that those breaches tend to be more expensive. This means

that healthcare providers should be making information security, particularly of personal data, a priority, if only for financial reasons.

The Ponemon Institute study also includes findings on the most effective methods of reducing the cost of a data breach. The study found that the two factors which reduced the cost of a data breach more than any other were:

- having an incident response team, which enables the organisation to respond quickly to a data breach to control the extent of the breach and mitigate the harm that results
- the extensive use of encryption to protect data during storage and communication, meaning that even if an information system is compromised or a record is accidentally disclosed or lost, the risk of an unauthorised third party gaining access to data is greatly reduced.

Other measures which reduced the cost of a data breach included employee training, use of security analytics and obtaining cyber insurance.

Kennedys' cyber and data protection practice can assist healthcare service providers in implementing preventative measures and in responding to a data breach.



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Cultivating a positive team culture

Creating a cohesive and harmonious team is one of the hardest things to do as a team leader. While each medical team faces unique challenges, inherited traditions that have normalised unprofessional behaviour are a barrier for many. We outline some strategies for overcoming these obstacles by creating positive teams.

Staff engagement is a distinguishing feature of organisations that deliver safe and efficient healthcare. Having systems in place can encourage positive contributions and commitment. Consider whether the following suggestions would work in your team.

1. Strengthen team relationships

- Establish a corporate social responsibility program and give back to the community.
- Plan an annual or quarterly social event outside of work hours.
- Incorporate fun into team meetings by starting with an appropriate joke or story, offering door prizes, or facilitating icebreaker exercises.

2. Lead by example

- Model desired behaviour, especially during challenging situations. People are more likely to treat others with respect if they are treated with respect.
- Work with your team and help them complete tasks, especially at busy times.
- Empower employees to fix problems themselves and respond to difficult situations. Be readily available and supportive when necessary and do not interfere when you are not required.
- Openly share information.
- Embrace a non-hierarchical leadership style.

3. Show appreciation

- Ask staff to complete a questionnaire about their favourite things, for example flower, sweet treat, magazine, colour. Use this information to reward individuals.
- Set up a gratitude wall.
- Share small wins in team meetings.
- Provide healthy snacks such as nuts and fruit in common areas.

4. Encourage suggestions for improvement

- Schedule a regular and non-judgemental continuous improvement meeting for questions, suggestions and concerns to be discussed.
- Directly ask individuals what you can do to improve things and act on these ideas.

5. Put things in perspective

- Highlight individual accomplishments and share stories that show the value of what they do.
- Actively promote (and role model) healthy work-life balance. Morale suffers when personal, social and family obligations cannot be met.

6. Help team members develop and grow

- Invite individuals to share their knowledge at a monthly meeting, for example discuss articles or teach a skill that is not necessarily directly applicable to the workplace. This also creates an opportunity for team members to get to know one another better.
- Provide opportunities for staff to reach their professional goals through education and training, such as organise a facilitator to run a workshop in the workplace, send team members to conferences, enrol them in a webinar.
- Conduct regular structured or “on the fly” coaching sessions.

Remember that effective change takes time and requires sustained commitment by everyone involved.

MDA National Education Services



References available from the Editor on request.

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Aboriginal and Torres Strait Islander substance use and wellbeing

Most Aboriginal and Torres Strait Islander people do not use alcohol and other drugs at levels that are risky to their health. However, hospitalisation and mortality rates related to the use of these substances continue to exceed those of the non-Indigenous population. In 2011, alcohol was responsible for 8.3 per cent and illicit drugs for 3.7 per cent of the total burden of disease among Aboriginal and Torres Strait Islander people.

Alcohol and other drug use can have a big impact on the mental health of users. However, it must be remembered that Aboriginal and Torres Strait Islander people view health as holistic, encompassing mental health and physical, cultural and spiritual health. Traditional culture does not recognise mental health or physical health as distinct medical issues.

The Aboriginal sense of self was traditionally seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The cultural protective factors that contributed to a stable and optimal sense of mental health and social and emotional wellbeing included:

- relationships and kinship - important for defining social roles
- spiritual beliefs - offered guidance and comfort in times of distress, death and loss

- customary law - defined rules and consequences
- tribal Elders - were highly respected and interpreted the Lore
- men and women - had defined economic and cultural roles.

For Aboriginal and Torres Strait Islander people who are hospitalised for 'mental and behavioural disorders', data from 2013-15 shows that the age-adjusted separation rates for mental and behavioural disorders due to 'psychoactive substance use disorders' were 3.6 times higher for Aboriginal and Torres Strait Islander people than those for non-Indigenous people. Similarly, the rate for 'mental disorders due to substance use' was five times higher for Aboriginal and Torres Strait Islander males than non-Indigenous males.

Substance use figures prominently as a factor for mental illness among Aboriginal and Torres Strait Islander people and is often used by individuals to help cope with the common life stressors such as:

- poverty
- racism
- death of a family member or close friend
- overcrowding
- serious illness or disability
- incarceration of self or a family member
- trauma
- being a member or family member of the Stolen Generations.

Interventions to address harmful alcohol and other drug (AOD) use among Aboriginal and Torres Strait Islander people are important for restoring the health and social and emotional



wellbeing not only of individuals, but of their families and communities.

The Australian Indigenous Alcohol and Other Drugs Knowledge Centre (www.aodknowledgecentre.net.au) is a web-based resource that aims to reduce harmful substance use among Aboriginal and Torres Strait Islander people by providing the evidence base to inform policy and practice. The Knowledge Centre provides free online access to a comprehensive collection of relevant and culturally appropriate AOD knowledge-support and decision-support materials for practitioners, community members, policy-makers and others involved in reducing harmful substance use.

Better access to information and knowledge is required to improve approaches to harmful substance use among Aboriginal and Torres Strait Islander people. Doctors require access to a range of

materials such as patient education resources, guidelines and research; communities need access to relevant, culturally appropriate and up-to-date information; and governments require current, evidence-based policy support materials. The Knowledge Centre achieves this through its program to develop a suite of knowledge exchange tools and resources that provide information that is timely, accessible and relevant. These include animated infographics, eBooks, webinars and short films in addition to the most comprehensive bibliographic data base of published research, programs, policies and projects. In addition, the Knowledge Centre fosters collaborations within the communities of practice in the sector with the provision of Yarning Places (electronic networks that enable people with an interest in Aboriginal and Torres Strait Islander health to share information) and other social

media such as Facebook and Twitter.

The Knowledge Centre is managed by the Australian Indigenous HealthInfoNet, which has a well established reputation for providing quality, evidence-based information and knowledge to inform practice and policy through its web resource - www.healthinonet.ecu.edu.au. The HealthInfoNet is assisted by a governing Reference Group and three national research centre support partners, bringing together a broad range of stakeholders and experts in Aboriginal and Torres Strait Islander AOD use.



Kathy Ride
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References available from the Editor on request.

Should property investors behave like first home buyers?

Simplicity is often the hallmark of successful investors. They take an approach to asset selection that, in hindsight, can seem obvious and unremarkable. But they of course have other talents, not least the courage to act quickly and decisively when they see an opportunity.

Property investment is no exception to this formula. Success depends on identifying where future demand will be strong, persistent and always a step or three ahead of its dogged pursuer, supply.

The thoughtful property investor will therefore routinely monitor drivers of supply and demand to check whether significant shifts in behaviour are emerging. The return of the first home buyer (FHB) over the last 12 months is one trend that deserves attention. As of June 2018, FHBs secured 18.1 per cent of all housing finance commitments, according to the ABS. That's a strong recovery from the 12.9 per cent nadir of October 2015 and the best outcome since October 2012.

Strong FHB activity appears to be driving prices higher for assets that sit in the typical FHB budget range. CoreLogic's May 2018 Decile Report showed that prices for capital city properties overall were flat across the 12 months to April 2018. But



properties valued between \$437,000 and \$655,000 recorded annual growth above 3 per cent.

The resurgence of FHBs has, in great part, been orchestrated by state governments who have improved stamp duty terms for this cohort over the last year or so. And with benefits applicable for properties sold up to \$750,000 in Victoria and \$800,000 in NSW and no sunset clause in place, it may well be the case these budgetary measures will act as a stimulus for this sector for another two to three years.

Another two to three years of beating overall market capital growth by more than 3 per cent would be an enticing prospect. Moreover, who knows what else the federal or state governments might do? The times of really high FHB finance commitments - 31.4 per cent in May 2009, 26.1 per cent in July 2001 and 24.5 per cent in May 1997 - eventuated after the federal government provided further largesse to FHBs. And yes, these previous highs were all followed by strong growth in property prices.

State governments make it very easy to execute an investment strategy that mimics FHB behaviour. Most of them release detailed statistics on the top suburbs where first FHB grants were deployed in greatest numbers. But this is where the strategy comes unstuck for me. The data shows that FHBs tend to buy in city-fringe locations. Places like Tarneit in Victoria or Liverpool in New South Wales.

That's understandable from a lifestyle perspective. But it is unlikely to be an effective investment strategy in the long-term.

Unfortunately, while today's city fringe area may feel like a frontier into the bush, by the next decade it is just another outer suburb. And the lack of scarcity of this property type will hold prices back over the long-term.

However, there are benefits for investors who are mindful of the rejuvenation of the FHB. Not all FHBs go to the fringe. There are some to be found wherever there is property in their budget range. It only takes a few FHBs to be active in a place where volumes are low to move prices upwards. So if you have less than say \$750,000 to deploy, keep looking for those scarce assets. Simplicity works.



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Top places to see spring flowers across Victoria



As Victorians store their winter coats and start watching for swooping magpies, Parks Victoria has collated the top spots across the state for stunning flower displays. After a long cold winter, now is the time to step outside and enjoy the physical and mental health benefits that come from being in nature. Head to these top spots right across Victoria.

Pink Lakes, Murray Sunset National Park

Located in Victoria's Mallee region, a two-hour drive south of Mildura, are wide-sweeping plains covered in flowers - iridescent pink pigface and the whites and yellows of many daisies and wattles, all offset by the backdrop of white and pink salt-encrusted lakes.

Best time for flowers: Early September to mid-October

**Wildflower Drive,
Greater Bendigo National Park**

The regional city of Bendigo is surrounded by forest that comes alive with wattle and other flowers from August onwards. In particular, check out Wildflower Drive just south east of Bendigo which is transformed with bright yellow wattle beneath the box and ironbark trees. Or in the middle of Bendigo, visit Salomon Gully Nature Conservation Area.

Best time for flowers: Mid-September to October

**Gorge Scenic Drive,
Beechworth Historic Park**

On the outskirts of Beechworth in north east Victoria, purple, yellow and white wildflowers abound. Take a slow drive or walk around the historic Gorge Scenic Drive. Walking tracks meander through the area and the bush is transformed with spring colour. If you've got a bit more time on your hands, head to the nearby summit of Mt Pilot, a 15-minute drive away, for sweeping views and more flowers.

Best time for flowers: September to early October

**Lerderderg campground area,
Lerderderg State Park**

Just over an hour north west of the Melbourne CBD is this remote park, which turns on a surprising display of colour. Check out wattles, peas, heath and orchids. Enjoy a sea of orange and white flowers off Upper Chadwick near the new Lerderderg campground.

Best time for flowers: Late September to October

**Anglesea Heath,
Great Otway National Park**

Under two hours from the Melbourne CBD and home to about one-quarter of Victoria's plant species, if you love orchids this is the place to visit. You'll find flowers right throughout the Heath, but in particular try Bambra-Aireys Inlet Road and Bald Hills Road.

Best time for flowers: Mid to late spring onwards

For those who want to stay close to Melbourne there's plenty of places to enjoy beautiful floral displays...

**Dandenong Ranges Botanic Garden,
Olinda, Dandenong Ranges**

Just a stone's throw from the eastern suburbs of Melbourne lies an extensive display of spectacular flowers. Entry is free and you can walk around the

gardens or catch a ride on the garden explorer before enjoying lunch at the cafe. Or to avoid the crowds, why not visit nearby George Tindale Memorial Garden, Pirianda Garden or Alfred Nicholas Memorial Garden?

Best time for flowers: Throughout spring. See the rhododendrons and azaleas later in the season.

Werribee Park, Werribee

For large scale formal floral displays you can't go past the Victorian State Rose Garden and the grounds around Werribee Mansion. The parterre plantings near the mansion will delight and you'll find every rose imaginable in the rose gardens.

Best time for flowers: Roses from September to March, with the peak in November. Flowers around the mansion from mid-September onwards.

If you don't make it during spring, never fear, many areas are still flowering in summer, especially in the alpine region.

**Falls Creek area,
Alpine National Park**

Take a walk along any of the tracks on the Bogong High Plains, in particular to Fitzgerald's Hut or Wallace's Hut, to enjoy colourful panoramas that would make photographer Ken Duncan envious. Masses of delicate daisies, everlastings, peas and flowering shrubs stretch across the high plains throughout summer.

Best time for flowers: December to January

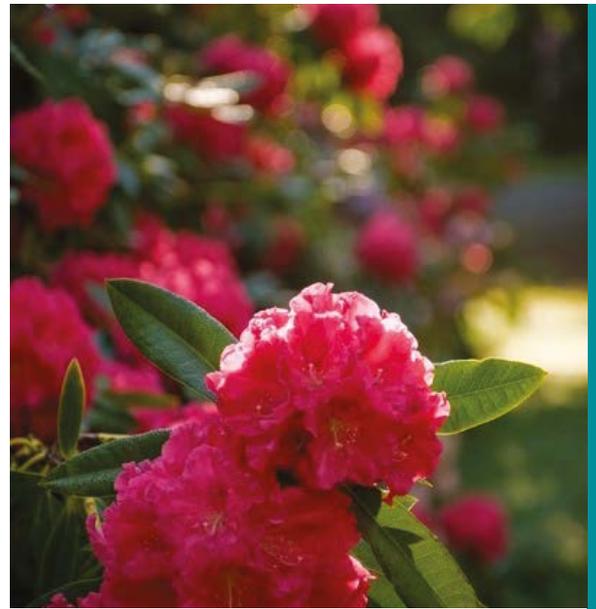
Events

If you love a guided walk or flower show, keep an eye out in your local area for events. Some places that host events over spring include Wilsons Promontory National Park, Kooyoorra State Park, Terrick Terrick National Park, Anglesea Heath and the Victorian State Rose Garden.



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Weather, including temperature and rainfall, can alter the amount of flowers and the timing of the flowering season each year.



Pictured opposite - Murray Sunset National Park.

Pictured from top to bottom - Rhododendron, Wattle, Daffodil (All photos: Parks Victoria).



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