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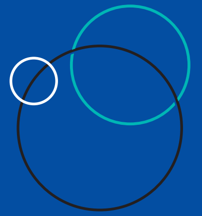


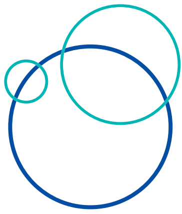
Illawarra Division of General Practice

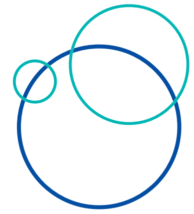
governance ~ practices ~ community

Summer 2009

catharsis health reforms reflections

taking it to the streets electrons behaving badly





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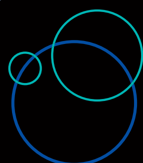

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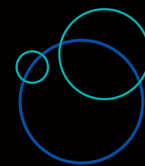

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Trilogy, Summer 2009

December represents the coming of Summer and, to our coastal strip, the coming of many tourists. It sees the end of another year's training of GP Registrars for many members, and for others, the halfway point for medical student placements.

Hundreds of people are turning out for the opening of the Illawarra Health and Medical Research Institute and most are sending apologies for end of year parties they are too committed to attend. A hectic time that complicates a crowded work schedule for most GPs .

But not all GPs.

In Summer's Trilogy, we present a special edition that reflects on the lives of three GPs who have not lived to see this Christmas; of three practices that have faced similar challenges of loss and of three people who have left a community better off for their service and sacrifice.

Catharsis gives its own overview of what's happening and what's not. The closure of the WAN after 10 years of almost seemless operation is a reminder of just how far ahead of the rest of Australian general practice the Illawarra has been in IT/IM.

A Season of Health Reforms is an important article as it addresses some of the miscommunication that has occurred around Primary Health Care Organisations. The article takes a federal perspective and ignores the consequence of a Liberal Government in NSW and the advent of District Health Boards.

What goes down and **From the pharmacopoeia** give a real life perspective of the desirability or otherwise of bleeding and not bleeding. Meanwhile, "the bleeding heart" could well be the theme of the **Taking care of business** article on the new "Modern Awards". This critical article may well be the catalyst for many GPs to seek professional advice concerning the new awards and for others to throw up their hands in dismay at their lot in life in being employers.

"Disasters we almost had", may well have been the title of **Electrons behaving badly**. Three case scenarios illustrate the importance of a systematic approach to information management.

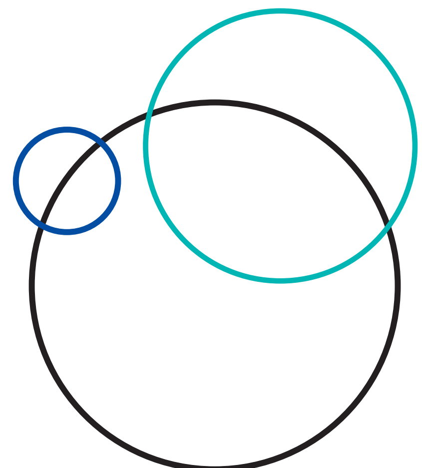
The Illawarra lags behind in the pap smear stakes and comes **Under the Microscope** this edition. Just as we recently reported our one thousandth patient coming through headspace, we can also report our thousandth patient screened under the cervical screening project funded by the Cancer Council in an attempt to improve Illawarra's pap test rates.

To complete the season's offerings we have an update on the **Antenatal Shared Care Program**. In **Cleared for landing** we can pat ourselves on the back for a spectacular level of normal deliveries.

And that completes the cycle of life for Trilogy.

May your Christmas be truly peaceful and have the significance that you would want it to have for you and your family no matter what circumstances have brought you in 2009.

Andrew Dalley



Catharsis

Catharsis, a Division update to become a regular feature of Trilogy, gives a broad overview of change in your member based organisation.

governance

Unique WAN service terminated

Two events have culminated in the Division's decision to close the WAN link with the Area Health Service.

Apart from an unacceptable rise in technology costs, the functionality of the WAN has been declining since the amalgamation of the two Area Health Services. Area's decision to cut Illawarra's GPs adrift from GP Gateway (funded by the Commonwealth Government through IDGP) was a significant blow to Illawarra's IT capacity.

However, the recent decision to move all GP correspondence through Argus has made the WAN redundant. IDGP acknowledges the relationship that existed with the former Illawarra Area Health Service and their commitment to innovation and integration.

Dr Liz appointed to top uni position

Former IDGP Chair, Dr Elizabeth Magassy, has been appointed to the University of Wollongong Council on the recommendation of NSW State Minister Verity Firth (Minister for Education and Training, Minister for Women).

The University Council is the supreme governing body of the University. Dr Liz' appointment is recognition not only of the contribution she has made to the profession but a reflection of the growing importance of general practice as seen in the local community.

Family Doctor Awards 2009

Over 1,500 nominations were received for the 2009 Family Doctor Awards. The award for Illawarra GP of the Year for 2009 went to Dr Sajid Azam of Bellambi.

Typical of the comments made about Dr Azam:

"My doctor has helped me overcome drug addiction and made me realise that I deserve a better life and that my kids deserve a better father. He has saved my life and I will always be grateful. He has never judged me and discriminated against me, but has taught me to value and appreciate myself and my life."

Dr Jenny Smiley received an exceptional mention. "Dr Smiley exercises genuine concern for her patients; being friendly, sympathetic, listens attentively, covers all needs completely and journeys with her patients through to wholeness."

Practice of the Year was awarded to Fairy Meadow Medical Centre for their multi-disciplinary and multicultural approach which was appreciated by all their patients.

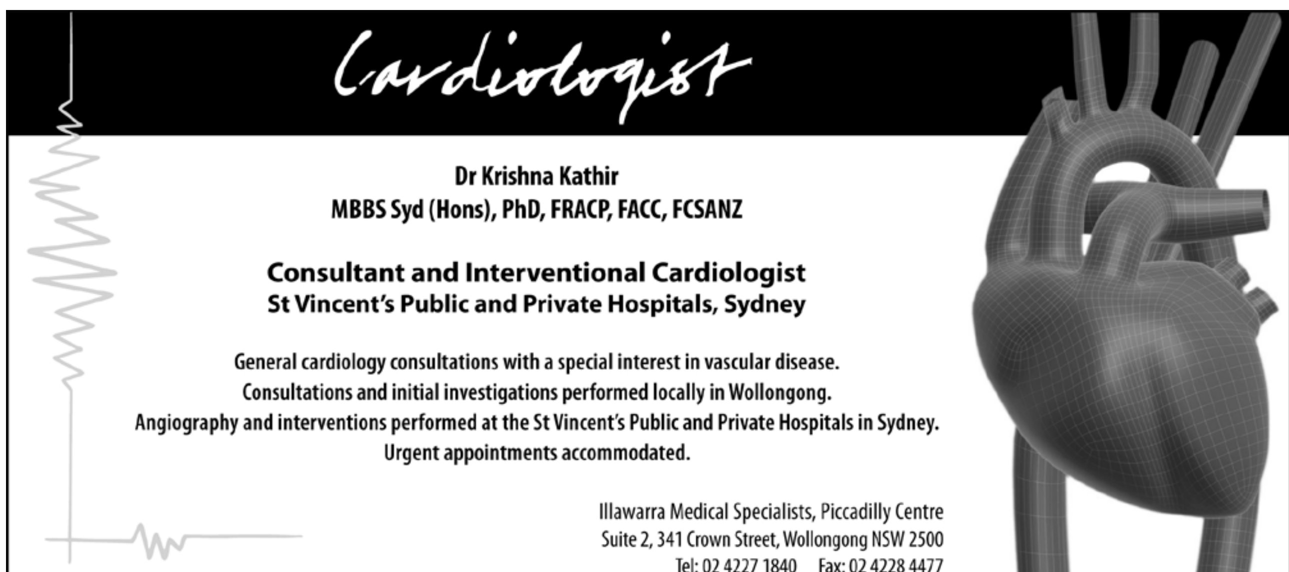
IDGP AGM 2009

The IDGP held its Annual General Meeting on October 22. It was a very successful night, with record attendance levels. Dr Andrew Dalley, retiring CEO of the Division reflected on "General Practice Change: Demise, Iteration or Evolution?"

The bi-annual peer nomination awards were also held. These give GPs a chance to recognise the outstanding work of their colleagues – two winners were announced this year, Drs David Grant and Ananth Rao.

There were also a couple of major changes to the Board. Dr John McAlpine has stepped down after three years as Chair. Dr McAlpine has been on the Board since 2002, stepping up to the position of Chair in 2006.

He has provided excellent corporate



governance and leadership to the Board during a period of significant growth and change for the organisation. Taking on the role of Chair is Dr Russell Pearson, with Dr Stephen Lyon being appointed as Deputy Chair. A new appointment to the Board is Dr Natalia Bakhilova from Kiama.

Upcoming CPR Training

The NSW Surf Life Saving runs monthly CPR courses out of the Wollongong Master Builders Club.

The cost of attending CPR training is $50. All courses run from 9:30am to 12:00pm.

Upcoming dates include:

1. Wednesday 20 January 2010
2. Saturday 20 February 2010

NSW Surf Life Saving will run a CPR training session at your practice for a minimum of five participants.

Farewell to some friends

Louisa Raft, a long term and highly valued staff member of IDGP, is moving on. Louisa is taking up her own consultancy after a varied and successful career at IDGP.

Many members will remember that Louisa was appointed Operations Manager following Liesel Wett's career upgrade. Having returned post childbirth, Louisa went on to establish headspace Illawarra.

Claire McLeod, Senior Clinical Psychologist, will also be greatly missed following her decision to specialise in Neuropsychology. Claire has been with the Clinical Psychology Service from the start and has played an important leadership role in that service broken only while she gave birth to, and cared for, her 26 week twins.

Nurse led clinics for CHD

The IDGP is embarking on a project to assist overworked GPs to establish nurse-led clinics for patients with CHD. Practices involved will receive intensive support from IDGP to design an appropriate clinical model, based on individual practice needs.

The evidence suggests that a nurse-led clinic for the management of some chronic diseases has positive outcomes for the GP, the practice nurse, the administration staff and ultimately, the patient. If you think that your practice could benefit from the establishment a nurse-led clinic for CHD, please contact Katherine van Putten, NiGP Project Officer: 4220 7644.

IDGP makes CAT available to practices

The PEN Clinical Audit Tool (CAT) is a clinical information system that supports quality improvement and enhances the business capability of general practice.

CAT is a clinical information system that puts the GP and practice staff in the driving seat where they can target patients with particular conditions or those with specific health risk profiles. It is simple to use. CAT provides reports on such things as patients' Diabetes and CHD results, progress towards claiming diabetes SIPs and much more.

With a few clicks of the mouse the practice has graphs that are easy to understand and relevant to everyday work, accompanied by related lists of patients. The Division will be rolling out the PEN CAT over the coming months. Practices need to have Medical Director, Best Practice, Zedmed or Genie. CAT will hopefully be adapted for Profile. For more information please email or phone the Practice Support Team on 4220 7600 or practicesupport@idgp.org.au.

Mental Health Item Number Changes - January 1

A new MBS Item number for Mental Health Care plans will come into effect on the 1st of January 2010. Up until then general practitioners can continue using the current item 2710.

Changes that must be implemented immediately include:

- Changing the name of the plan from the 'GP Mental Care Plan' to the 'GP Mental Health Treatment Plan'
- GPs must now include a diagnosis in treatment plans

After the 1st of January 2010 GPs who have completed Mental Health Skills training will be able to continue to use the existing item 2710. GPs who have not completed Mental Health Skills Training will use a new Item number which will be at a lower rebate $126. (the current rebate is $156).

Accredited sessions can be completed face to face or online. GPLearning offer accredited online modules at www. gplearning.com.au. For further information please contact the GPLearning helpdesk at 1800 284 789.

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A Season of Health Reforms

The National Health and Hospital Reform Commission released a report which recommended sweeping changes to what we loosely call our health system. However, it is one of the more boring recommendations which nonetheless seems to have captured the imagination of many GPs; the Primary Health Care Organisation (PHCO). In A Season of Health Reforms, Andrew Dalley gives an overview of what we know about the planned PHCOs.

Introduction

PHCOs are not to be confused with "Comprehensive Primary Health Care Centres" which have been described as super superclinics. At this stage there is no relationship between the two.

The PHCO is poorly described in the NHHRC report but much has been read into that description that doesn't exist in reality. In fact, the role to be performed by PHCOs is described as follows: "Primary Health Care Organisations (evolving from or replacing Divisions of General Practice) should provide future service co-ordination and population health planning within local communities."

Defining the differences with Divisions of General Practice: the difference between PHCOs as described in the NHHRC Report and Divisions of General Practice may be summarised as follows:

1. Size

PHCOs are going to be bigger geographically. Recommendation 21 says that PHCOs should "be of an appropriate size to provide efficient and effective coordination (say, approximately 250,000 to 500,000 population depending on health need, geography and natural catchment)".

They're also going to be broader in membership in that primary care clinicians of all types would need to be engaged to some extent to enable any sense of meaningful service co-ordination. How this would be achieved is not described.

2. Governance

The Minister has stated that PHCOs will not be Statutory Authorities (AGPN Forum, 2009). Given that, PHCOs are most likely to be companies limited by guarantee as is the Division currently. However, the governance structure will be required to "reflect the diversity of clinicians and services forming comprehensive primary health care" (recommendation 21).

3. Population health planning

This is new. Population health has hitherto, in NSW at least, been the responsibility of Area Health Services. It will require significant data collection and management capacity.

4. Service co-ordination

Many Divisions have little experience in this area. IDGP has been engaged in the Illawarra Co-ordinated Care Trial, ILUC, headspace and the Clinical Psychology Service so would seem to have some advantage in this area.

Keeping what's worked

If IDGP members choose to move IDGP on into a PHCO, it would be expected that we would insist that existing GP services were transferred. These would include:

1. OTIiS
2. Practice support staff
3. Home Medicines Review
4. NPS support
5. CPS
6. ILUC (Illawarra leg Ulcer Clinic)

In summary, the NHHRC Report is light on detail but recommends PHCOs should be bigger than Divisions of General Practice and similar in function apart from a population health capacity.

The most demanding challenge on a PHCO would be making services "joined up" (K Rudd, July 2009), ie making the patient journey through multiple providers easier.

AGPN view

AGPN has released their own "Blueprint" for PHCOs. That's a different picture. They start by emphasising the centrality of general practice to the success of PHCOs.

They suggest that PHCOs should commence in June 2012 when the main contract for Divisions of General Practice expires. The important additional recommendations to those of the NHHRC include:

1. Services to general practices
2. Services to the community for disadvantaged people
3. Health promotion
4. Workforce support (at present other agencies are funded for this task)
5. That PHCOs are specifically tasked to facilitate interdisciplinary education and research in primary care.

Bit more dramatic than the NHHRC but, at this stage, no great changes for Illawarra GPs.

Funding as recommended by AGPN

The NHHRC Report does not make any recommendations on funding for PHCOs but the AGPN Blueprint does. Funding sources suggested by AGPN include:

1. Existing Divisions' funding (which would be relatively greater due to reducing the number of boards, CEOs, Finance and HR managers, etc)
2. Community Health funding. This is a major recommendation as Community Health has (or used to have in the Illawarra) large staff numbers. However, the recommendation is logical in that they are the experts in health promotion. This recommendation is particularly important in NSW which has seen Community Health used

A Season of Health Reform continued

as a vehicle for supporting early discharge of elderly patients from hospitals – an entirely inappropriate role for Community Health staff.

3. Other (unspecified) Commonwealth funding that currently goes to NGOs. This could be quite a controversial recommendation.
4. MBS and PBS are specifically excluded from the funding model.

Governance as recommended by AGPN

The Blueprint refers to two options for Divisions; viz amalgamation or the formation of a new organisation. The Board of each PHCO would be "skills based". This means that there would be a mix of GPs (and other clinicians) with people with particular skills relating specifically to governance.

Membership would be either individual or by representative group. This is an important distinction. A large PHCO would not only have perhaps 500 – 700 GPs as members (if they chose to join) but many other allied health professionals as well. This is the major risk to GPs but a risk which can be mitigated by appropriate Articles of Association.

Summary

The NHHRC Report is light on detail about PHCOs. AGPN has entered the debate with wider ranging recommendations but which still lack detail. There is no suggestion that PHCOs take over the funding of general practice but there is a recommendation that they do take over Community Health funding.

There is no suggestion that GPs will have to belong to a PHCO as indeed a small number are not members of Divisions of General Practice

If PHCOs work, they will have achieved two outcomes. They will have made the patient journey easier for patients and for GPs and they will have improved access to health care by the population in general and by the marginalised in particular. Both are considerable challenges.

Unmentioned in either document is the important outcome to make general practice an attractive career option for young medical graduates. It must succeed on that basis or anything else is just shuffling the deck chairs.

governance

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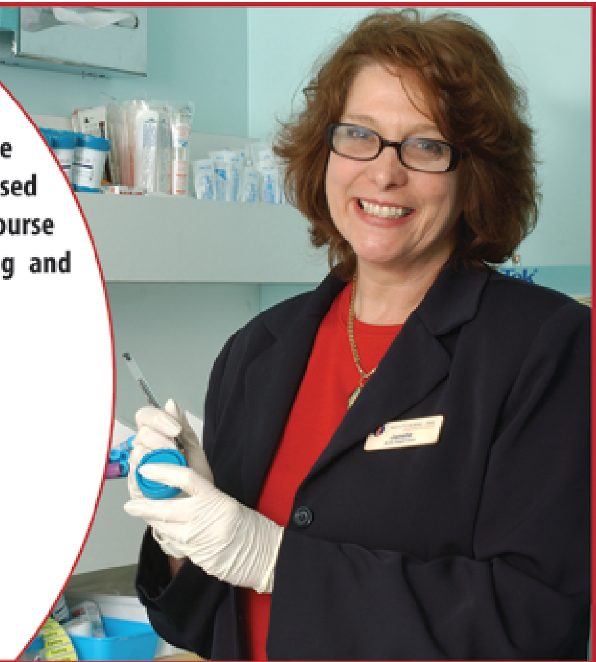

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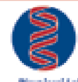

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Reflections

Reflections

community

community

Dr Margie Carman —

Popular Bulli GP Dr Margie Carman passed away in April of this year. For this interview Dr Julie Blaze spoke about the impact that the death of Doctor Margie Carman had on the Bulli Medical Practice, the Bulli Community and on Dr Blaze herself.

Dr Carman the person

A love of performing followed Dr Carman throughout her life, as she got older she became a member of the Sutherland Choir. "Margie was an active, energetic individual with lots of life experience. She was passionate about travelling and did a lot of adventure trekking. She had a love for the arts and was a terrific performer, having a great passion for music and folk singing, in particular. She loved the Theatre. Many years ago I remember watching her perform in an alternative version of the Phantom of the Opera";

On the home front, Margie was the proud mother of two children, Jane and Mark. Her daughter Jane is a talented violinist, who now studies Music at a Sydney University. "Margie often spoke about how proud she was of her daughter and her musical gifts".

Dr Carman the GP

Dr Carman brought experience and expertise to the practice in regards to her work with patients with mental health problems. She was also dedicated to scientific principles and evidenced based medicine.

"Margie was drawn to mental health. She worked 2 days a week as a GP at our practice and spent 1.5 days focused on psychological medicine. In regards to Margie's work in mental health she focused on an evidence based clinical approach to treatment. Her work in this field meant that she had a deep relationship with her patients. This was extremely apparent through the deep loss that Margie's patients expressed at the time of her death."

Dr Carman also had an interest in teaching new medical graduates. One day of the week Margie worked at the Sutherland Clinical Teaching Unit. And she loved working with families and, in particular, children. Even after moving to the Illawarra she worked at the Kareena After Hours GP Medical Service at Miranda. Indeed, her loss is mourned as much in the Sutherland district as it is in the Illawarra.

What impact did Margie 's death have on the practice?

"Devastating; the nature of her death was unexplained and it took time for everyone in the practice to accept. The event was completely out of the blue. One day Margie didn't turn up for work and a week later her body was found. As a practice we had no way of preparing for the shock of the event.

"We offered counselling to all staff. I knew Margie on a personal level for many years and sought counselling from an external source at a later date. The police were involved in searching for Margie which made the whole grieving process difficult.

Has the loss brought the practice closer together?

The event blew the practice out of the water. It has been a difficult, traumatic 6 months. Only in hindsight can we all recognize how difficult the time was. As a practice we had to keep on going. Patients still needed our care. Dr Shelia Khoo came out of retirement to help out at our practice and we are very much appreciative of her support. It was one of those offers that you don't want to take up; you don't want to interrupt a person's retirement but we needed someone.

Margie was a prominent member of the Bulli community, with a lot of loyal patients. How will she be remembered?

"To honour the person Margie was, Bulli Medical Practice has become a major Sponsor of the Bulli Folk Festival. One day of the festival each year will be dedicated to Margie. Preparations are also underway for a memorial photo within our practice for Margie. We hope that this will provide patients with a lasting memorial to Dr Carman: caring GP, talented musician and proud mum".

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Reflections

Dr Vadanam Sundar —

Dr Vadanam Sundar passed away on the 10th of January 2009. Dr Sundar will be remembered as a dedicated, hardworking doctor who served patients in the Illawarra for 32 years. For Reflections, Dr Sumathi Sundar spoke about the impact that the death of Dr Vadanam Sundar had on their medical practice, the Dapto community and the family.

In the 1970s, Dr Vadanam Sundar had been working in the Indian Hospital system as a Post Graduate Student in Surgery. It was when the government tried to transfer him to a small village which did not have an operating theatre that his frustration boiled over to Australia's advantage.

In 1975 he made the life-changing decision to move to Australia. Initially unable to work as a Surgeon, Vadanam worked in a psychiatric hospital in Melbourne before moving to Wollongong Hospital in 1977.

In 1979, he made his first foray into general practice opening a practice in the Dandaloo shopping complex. Demonstrating the work ethic that was to become so evident throughout his life, he doubled up working in both general practice and the hospital.

It wasn't until the Sundars opened their practice in Kanahooka in 1983 that Vadanam concentrated solely on General Practice.

"Vadanam was a born Doctor", said his wife Sumathi.

"He was extremely popular with his patients who would come from all over the area to see him. One of Vadanam's strengths was that he treated his patients as friends, he went out of his way to help his patients."

"My husband was a man who loved to talk and often patients were treated to his stories about how he came to be working in Dapto or the state of the medical system in India. But Vadanam also listened to his patients and was interested in their stories."

Sumathi said of her husband that, "Vadanam didn't have much spare time".

A wonderful understatement about a man who wouldn't close the practice until 8:30 pm. He would then do his home visits. On Saturdays after closing the practice at 2:00 pm, again, he spent the rest of the afternoon catching up on home visits.

However following two coronary events in 1998 and 2003 he was forced to decrease his pace and hours of work. Sumathi joined her husband in practice in 1993 after completing her AMC exam and becoming fellow of the RACGP.

Of her children Sumathi says, "Our two children Sarika and Vikram realise their Dad was a wise man. Vadanam had experienced the trials and tribulations of life and was able to pass on his experience to them. Looking back I can see that Vadanam saw life in a different perspective; experience taught him that unfortunately you just can't trust everyone in this world."

Those who went to the funeral could not have helped but notice that the children admired their father and had a tremendous amount of respect for the man he was. This was evidenced by Sarika's decision to enroll in the GSM program at UoW.

Vadanam's death was completely unexpected. It was a Friday. He had gone to pick up their son Vikram from the airport and suffered a stroke on the way home. When he passed away his family and close friends were with him. Sumathi recalls,

"I was numb for the first few days. I found myself wanting to hear Vadanam's opinion on things. I wanted to speak to him. In those first few days I was so thankful for my children who were so strong."

Like many experiencing grief, Sumathi rose above her own needs to meet those of others.

"Vadanam's brother and sisters flew in from

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community

Dr Vadanam Sundar continued —

America and Melbourne. I remember trying to prepare our house for their arrival and feeling like I was a robot going through the motions. The Practice that had always been so busy fell silent on the Saturday.

A locum was found to work out of the practice for the next three weeks. It was a difficult time for the office staff who were continually asked about Vadanam and had to explain what had occurred."

"I was touched by the support that I received from our patients", Sumathi recalls. In the first weeks I received hundreds and hundreds of cards. It was great to see that my husband was so loved.But as a general practitioner it is challenging to go back to work after losing a loved one, as patients wanted to talk about my husband and it was difficult to focus on patient care."

Sumathi said that she received tremendous support from her fellow GPs. "I was constantly receiving phone calls from other doctors asking what assistance that they could offer."

On reflection, Sumathi was asked if she had any advice for others in her situation. "Each person has to find their own path, she said.

"What helped me was not feeling sorry for myself. There are a lot of people in this world who have experienced far greater hardship than I have. I am so thankful for the support that I have received from my family, colleagues and the community. "

"Vadanam knew that his end was near." For months preceding his death he mentioned this to Sumathi because "he wanted to prepare her."

As Sumathi described "Vadanam accepted this calmly and in a matter of fact way. As the ancient Persian poet Omar Khayyám said "The moving finger writes and having writ, moves on: nor all thy piety nor wit shall lure it back to cancel half a line."

"Nor all thy tears wipe out a word of it."

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Reflections

Reflections

Dr Garry Gow —

On the 30th of March Dr Garry Gow succumbed to aggressive form of multiple myeloma. Garry had served the Wollongong Community as a General Practitioner for 25 years. He will be remembered for his quiet demeanour and his compassion for his patients.

Garry studied Medicine at the University of Newcastle. He did a stint in England and trained in obstetrics and anaesthetics. When Garry came back to Australia he really wanted to be a GP, particularly as he liked contact with people and valued the relationships that he built with patients.

He was to meet his future wife, Lucia Appoloni, a Community Nurse, while doing locum work as a GP across New South Wales. Lucia fondly recalls, "When we first got together he came to see me in Wollongong, and then one week he stayed. We went out for three years, throughout this time Garry continued doing locum work". It wasn't until Garry and Lucia were married that he opened up the practice in Church Street.

Garry's gentleness was a product of his beliefs and his lifestyle. He was a devout Buddhist, who was strongly committed to his faith and was a benefactor for the Dalai Lama when he visited Australia. He loved cross country skiing and the quiet of the slopes. He was a member of the Nordic Ski Club, a group that took beginner skiers cross country. One of his pupils was Lucia whose skills lay elsewhere. "Garry tried to teach me, but I spent more time on my bottom then on my skis", she recalls.

The Church Street Practice was a homely Practice. Garry believed strongly in alternative medicine and it was natural that a naturopath and massage therapist also worked out of the practice.

Garry was a pretty amazing man. A lot of his patients had chronic health problems and Garry was so patient and gentle when he worked with them. Garry loved his work, even when he was sick Garry continued palliative care visits with patients.

And then the first symptoms, Garry kept complaining about a sore back. But his elderly mum was living with him and Lucia and Garry's back pain took second place to his sick mother. The morning came that Garry woke up and couldn't move. Garry, being Garry, organised his own ambulance. At the hospital he was diagnosed with advanced multiple myeloma and renal failure.

The initial prognosis was 8-10 years but that quickly diminished to two years. Toward the end, Garry and Lucia went to New Zealand for two weeks, despite the fact that Garry was in hospital up to the night before they left. Garry needed the time to see his Tibetan Buddhist Teacher Venerable Gesahe Sonam Rinchen, to say goodbye before his death. In that time, Garry and Lucia journeyed together. A final goodbye wasn't spoken but it was acknowledged.

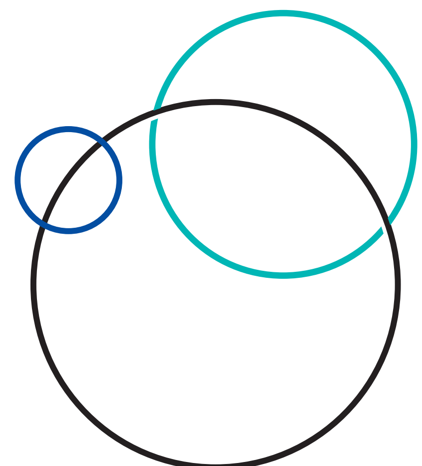
Following Garry's passing, Lucia found comfort in the overwhelming response to Garry's death, particularly the incredible number of letters of support from old patients. In particular, Garry felt strong support from his colleagues in the medical profession. Lucia noted that he often spoke about how he felt his fellow GPs were "pulling together". On reflection she said,

" I can see that Garry was a man who was deeply cared for. Through out the trials and tribulations of his life, Garry had fellow Doctors ringing him, offering their support. It was just incredible, something that Garry never expected when he entered General Practice all those years ago".

Lucia was asked how she now viewed the profession. Her reply is an important reminder to each GP of his or her contribution to their community of patients:

"Noble. General Practice is a complex field and a profession that I don't think you can work within unless you are a giving person. Working within General Practice is very demanding, I know from watching Garry that you have to give your all every single day."

Thank you, Garry Gow.



What Goes Down

Progressively more and more older people are using complementary medicines. Often these are not purchased from their pharmacy but instead ordered from bulk vitamin companies. In what goes down. Karina Bronska identifies some real life problems for GPs associated with complementary medicines.

practice support

An interesting case came to light recently when a 78 year old man on warfarin was found to be also taking 18,000mg of garlic and 4000mg of fish oil daily. Four other complementary medicines (CM) were also taken on a daily basis.

Neither his GP nor pharmacist knew that he was taking these supplements. This example illustrates how a home visit by a pharmacist can often uncover surprising and unexpected results.

Both fish oil and garlic will increase the risk of bleeding and this can occur without necessarily increasing INR, due to the different pathway of action. Fish oil consists of eicosapentaenoic acid and docosahexanoic acid.

These fatty acids may affect platelet aggregation and vitamin K dependent coagulation factors through lowering thromboxane A2 supplies within the platelet, as well as decrease factor VII levels.

This effectively increases anticoagulation. Concurrent use of garlic supplements and warfarin may result in an increased risk of bleeding due to additive anticoagulant effects; garlic may inhibit platelet aggregation through reduced thromboxane B2 and increased fibrinolytic activity.
Fish oil 3000mg per day or less can be safely used by most people. Doses greater than 3000mg per day can potentially increase the risk of bleeding. Advanced age is also an independent risk factor for major bleeding.

When the effect of age, in addition to other risk factors on the occurrence of major bleeding was evaluated, the results showed that patients aged 75 years or older had a 5.1% rate/year of major bleeds compared with younger patients with a 1% rate/year.

Information about complementary medicines

In 2008, the NPS commissioned an independent consortium from Mater Health Services in Brisbane, Bond Uni and Uni of Queensland to evaluate the quality of CM information resources. The review confirmed that many Internet sites are commercial, with a significant proportion failing to provide quality information or containing misleading information.

Nor surprisingly, online subscription databases featured in the top-tiered resources: Natural Standard (with professional and 'bottom line' monographs), Natural Medicines Comprehensive Database, Herbal Medicines and Dietary Supplements package (via MedicinesComplete). However, free databases such as MedlinePlus: Drugs, Supplements and Herbal information and EBSCO's Natural and Alternative Treatments rated highly.

Karina Bronska
HMR Program Facilitator
kbronska@idgp.org.au

Lifestyle Change — have a patient in need?

The NSW Health Get Healthy Information and Coaching Service is a FREE service that could assist some of your patients make lifestyle changes that will improve their health status.

Launched in March 2009 the Get Healthy Information and Coaching Service is a free telephone and web-based service staffed by qualified health coaches aimed at supporting adults make lifestyle changes regarding:

- Physical activity
- Health eating
- Reaching and maintaining a healthy weight

Patients can call the Get Healthy service on 1300 806 258. They will receive ten free individually tailored telephone coaching sessions over a period of six months. The health coaches are not there to offer medical advice but, provide information and ongoing personalised support designed to help your patients make lasting behaviour changes.

The primary target audience for the service are adults, 18 years and older at risk of developing chronic disease due to having one or more of the following risk factors:

- Not meeting healthy eating guidelines
- Lack of physical activity; and/or
- Overweight

Patients with a chronic disease can also use the service however they must obtain a medical clearance from their Doctor before they can enrol in the service. This form is available on the Division website.

This FREE service provides your patients with a great opportunity to receive ongoing support to make positive lifestyle changes that could improve their health outcomes. The service is funded for a two year period.

For more information visit www.gethealthynsw.com.au

From the Pharmacopoeia

In her article, HMR pharmacist Karina Bronska gives a real-life example of what is becoming increasingly common; and exemplifies the management problems associated with warfarin. In her visits to General Practitioners in the Illawarra on stroke prevention, Margaret Jordan has noted a common dialogue is, "what can be used instead of warfarin"? Aspirin is a known alternative which is less effective than warfarin and has been postulated to prevent strokes in the presence of AF that are of atherothrombotic (not cardioembolic) origin.In From the Pharmacopoeia, Margaret answers a few other questions.

"What about that one that was around a few years ago?"

This is in reference to ximelagatran (Exanta®), a direct oral thrombin inhibitor, which was close to being considered and approved for the prevention of venous thromboembolism after PE or DVT, and for stroke prevention in AF, when it was withdrawn in February 2006 because of cases of hepatocellular necrosis.

Even without this withdrawal, the cost was likely to be significant, as regular ALT monitoring was considered mandatory, and acquisition costs and those of managing potential bleeds meant that each patient would be approximately$2,500 worse off financially per year.

"What about that new one for hip replacement?"

Actually- not many GPs are aware of this oral direct factor Xa inhibitor, rivaroxaban (Xarelto®) which is PBS subsidised for post-operative prevention of venous thromboembolism after knee and hip replacement (for 14 days and 35 days respectively).

It has been approved as it is possibly more effective than sub-cutaneous enoxaparin (Clexane®) but probably has a higher bleeding risk. Presently, there is no data available for any other indications than these.

"What about aspirin and clopidogrel?"

Co-incidentally, this combination has been trialled compared to aspirin alone in stroke prevention in AF (ACTIVE trial); however the number of ischaemic strokes prevented with the combination (9 per 1000 per year) was similar to the number of major haemorrhages attributed to the combination (8 per 1000 per year) and so this combo is definitely not recommended.

The newly marketed combined medication with these 2 drugs is indicated only for continuation therapy after acute coronary syndromes (with or without stent placements) and not for following ischaemic stroke or TIA, because of the major risk of bleeding (as shown in this and the MATCH trials).

"Is there anything else new"

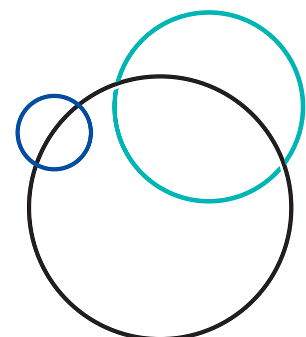
There is a new(ish) oral thrombin inhibitor with TGA approval for prevention of thrombosis after knee or hip replacement- dabigatran (Pradaxa®).

In a non-inferiority trial for prevention of stroke in AF, similar benefits and bleeding risks were observed as for warfarin, but with higher gastro-intestinal side effects, myocardial infarction rate and liver impairment.

As with many medications, there are significant drug interactions. Dabigatran cannot be used in patients with CrCl < 30ml/minute and as there is no antidote available, it is uncertain as to whether it will be the replacement to warfarin that many have wished for some time.

In the meantime I am currently visiting GPs on the use of warfarin, and antiplatelets in stroke prevention. I also am looking at prescribing of warfarin in nursing home and hostels, and so if you are interested in either of these please call me at the IDGP on 4220 7600.

Margaret Jordan
mjordan@idgp.org.au



practice support

Taking Care of Business

In Taking care of business, Toni Minovski, a Workplace Advisor from NSW Industrial Relations introduces us to the new world of Modern Awards. This is vitally important information for all employers.

practice support

Are you prepared for the move to a national industrial relations system next year? Will these changes affect your workplace? How can you prepare?

Employers need to be organised for the changes and be aware of their obligations and responsibilities as an employer. These may change in the very near future as for all practices in NSW there has been a significant announcement made that will affect your workplace arrangements regarding your employees

The NSW Government has agreed that all NSW private sector employers currently covered by the NSW industrial relations system (mainly sole traders and partnerships) will move into the national scheme from 1 January 2010. This means greater certainty, efficiency and fairness for businesses, with one clear set of rules covering conditions of employment, enterprise agreements and unfair dismissal.

The significant changes that started to occur from 1 July 2009 will apply to all private sector employees in NSW from 1 January 2010. From January 1, 2010, all employers in the national system will need to ensure compliance with the 10 National Employment Standards (NES) and, significantly, will most likely be covered by a new modern award.

The most likely award for general practitioners will be the Health Professionals and Support Services Award 2010.

This award is available to view in its draft form at the time of this article being put together. Visit www.airc.gov.au to obtain a draft copy of this award.

Employers who are constitutional corporations (corporations that engage in significant trading or financial activities) automatically fall within the national industrial relations system and more information is available at www.workplace.gov.au or by calling Fair Work Australia on 131394.

Employers who are currently under a state award will find that there will be a transition period for them to move to the modern award pay rates and they will need to find out more about how this will work. Other important changes that you need to also understand are the new unfair dismissal provisions that came into affect for all employers, covered under the Fair Dismissal Code for Small Employers.

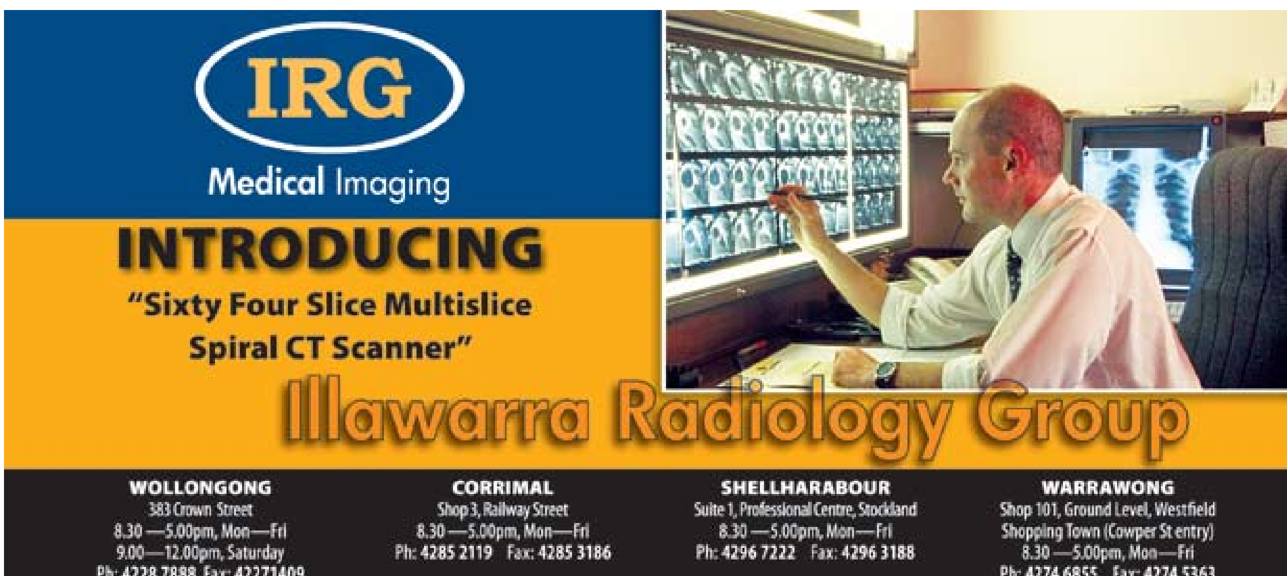
Employers will need to be prepared for these changes. They face specific requirements regarding employment records, the provision of pay slips and other obligations relating to the various leave entitlements under the NES.

Should you be interested in obtaining further information, NSW Industrial Relations will be running a series of workshops for employers in 2010.

Our IR in NSW and Modern Awards and Agreements workshops are two sessions that will better explain your rights and responsibilities.

For further information visit www.industrialrelations.nsw.gov.au or call NSW Industrial Relations on 131628.

Toni Minovskia



Electrons Behaving Badly— Avoiding Disaster

There have been three major incidents in October where practice servers have had catastrophic IT failures: two were hardware and the other software failures.

There are three factors that assisted these practices to minimise the impact on their business;

1. Good backups that had been tested regularly.
2. Documented procedures rapidly put a manual system in place.
3. A strong relationship with the surgery's IT support provider.

One of the measures that has proven valuable for practices to recover from problems and continue to see patients during IT outages is printing of appointments. At the end of the day printing the appointments attended that day and the appointments for the next day or even the upcoming week can make a big difference.

The physical copy of each day's appointments gives practices a starting point to re bill and reenter notes if required. The printout of upcoming appointments gives the front desk something to work with to manage the day's appointments. There are other simple measures that can be put in place and there are resources like the "Computer security policy and procedures manual template" that the IDGP PSO and OTIiS teams can assist with to help practices to reduce their risk by planning for disasters.

Backups

Saying 'it's ok, I do a backup' is not enough. Each of the sites that had the failures had backup verification and testing schedules in place aligned with accreditation standards. Each day practices should check and record that the backup has run and has been copied to the backup media. Then, every month your IT support service should verify that the backups occurred and check the log files. Every six months, IT support should recover the backup from the backup media and ensure the backup can be restored (this simulates a server failure situation and ensures that practice data can be restored from their backup).

There are several things that can go wrong with backups, some of the most common problems are:

- Backing up incomplete or corrupt data.
- Backups are not copying properly onto the backup media.
- Backups cannot be copied off the backup media.

OTIiS, is able to assist practices to develop procedures to verify and test backups. OTIiS can also assist with monthly backup verification and recovery testing through their maintenance packages.

Strong relationship with IT service provider

In my opinion a strong relationship with the practice's IT service provider has proven to be one of the major factors that has allowed sites to minimise the impact on their business and recover quickly from the server failures. Some of the key factors that practices should work on with their IT service provider are:

- IT provider has adequate staff resources, ie sufficient staff to be able to ensure they can have IT support available in the event of an emergency, and that more than one IT support staff member is able to provide your IT support.
- IT service provider is familiar with the practice. This will ensure that, in the event of an emergency, the IT service provider does not have to waste time orientating themselves with your practice.
- IT service provider has hardware resources. It is important that your IT support provider is able to provide loan or standby resources in the event of an emergency, to ensure that you are able to operate while repairs are made or new equipment is ordered.
- IT service provider is familiar with your clinical software package maintenance and recovery options. This will ensure that IT support can recover or restore your data without having to wait for the software vendor's help desk to reopen.
- IT service provider is aware of clinical pressures in running a general practice. This will assist the IT service provider to ensure the correct contingency measures are put in place in the event of a disaster to ensure a practice can continue to operate and to bring the critical resources back online first.

Quick review of the issues in October

At the site with the software problem, OTIiS staff worked through the night to rebuild the server for the next day's operations, ensuring the least possible impact to the practice. At the sites with the hardware failures, OTIiS staff put in loan servers and set up the sites clinical and practice management software from their backups so the practice could continue to function efficiently while new hardware was purchased. All three of these practices did have some adverse impacts on their operations because of the IT failures, but because of the long term relationship with OTIiS and the policies and procedures the sites had in place, the impacts were minimised.

Ray Fitch

IDGP Practice Support Service

Provides Support/Information in response to members' requests

- MBS Items (EPC/PIP/SIP/Health checks)
- Immunization
- Accreditation
- HR & IR
- IDGP services (LMPs, ILUC, CPS)
- IM/IT
- Orientation

Helps practices build system efficiency and compliance

- Accreditation
- Immunization
- IM/IT
- HR and IR
- Practice nurse modelling
- Practice Management
- Orientation for GSM students

Supports business Improvement and general practice outcomes

- Australian Primary Care Collaboratives
- Data extraction/clinical audit

Support methods used

Support is provided by phone, visit, email and fax. Education workshops and on-site education are provided for practice nurses, practice managers, admin staff and GPs. Service packages provide specialized support.

The IDGP website

Provides resources, links, latest news and a range of EPC, SIP/PIP, HMR and local services templates. www.idgp.org.au

P.S. newsletter

Is produced quarterly. Includes immunization, accreditation and education and current issues

Team Members

Linda Blackmore, Manager

Margaret Liackman, Practice Support Officer

Chris Pitt, Practice Support Officer

Kathy Lymbery, Practice Manager

Kristie-Lee Last, Administrative Support

Alison Burling, Education and Publications

Katherine Van Putten, Cervical Screening Project Officer.

Contact Us— Email: practicesupport@idgp.org.au **Phone:** 4220 7600 **Fax:** 4226 9485

Under the Microscope

The Facts: Cancer of the cervix is the eighth most common cancer in Australian women, yet is also one of the most preventable and curable of all cancers. Up to 90 per cent of the most common form of cervical cancer could be prevented if all women had regular two-yearly Pap tests.

NSW Cervical Screening Program in the Illawarra.

We know the facts. Why is it then, that throughout NSW 1.7 million women are at risk of cervical cancer because they are not screened in line with national policy? If we look at the local picture, the situation is even worse, with cervical screening rates for the combined Illawarra area being consistently below the NSW State average.

Table 1 shows a comparison of Illawarra Local Government Area (LGA) screening rates compared with the NSW overall rate for the biennial screening period. The table shows women in the Wollongong and Shellharbour LGAs are at greatest risk of developing cervical cancer due to underscreening. Screening rates in the Kiama LGA are better than the NSW average, however, up to 38.2% of women who live in the Kiama LGA are still not screened according to guidelines.

Table 1: Comparison of Illawarra and NSW State biennial cervical screening rates for NSW Cervical Screening Program target group (women aged 20-69)

Period	Wollongong LGA	Shellharbour LGA	Kiama LGA	All IDGP Area	NSW All
2004-5	55%	51.9%	61.8%	56.5%	57.1% (a)
2003-4	57.1%	55.2%	66.2%	57.3%	58.9% (b)
2002-3	57.3%	54.8%	65.2%	57.7%	59% (c)

What can you do?

Studies have shown that a recommendation from their GP will influence many women in making the decision to have regular Pap tests. The easiest way to introduce the subject is simply to ask "While you're here, can we check when you last had a Pap test?"

Some other strategies that can be used by GPs or practice nurses to increase the likelihood of women having a Pap test every two years include:

- Using information from your clinical software program to identify women who have never had or who are overdue for a Pap test and recalling them.
- Using a computerised or file tag reminder system to alert you when a patient is next due for their Pap test.
- Contacting the IDGP Cervical Screening Project Officer, Katherine van Putten, for assistance to access NSW Pap Test Register Data for women overdue for a Pap test and organising a mailout to encourage attendance at a nurse- run cervical screening clinic.
- Make sure women are physically and psychologically comfortable when having a Pap test.
- Make sure every woman gets her results and knows when her next test is due.
- Using resources in community languages from the NSW Cervical Screening Program to explain to women the importance of a Pap test every two years.

Support from the IDGP

The IDGP currently has funding from the Cancer Institute NSW to work with general practices in Wollongong and Shellharbour LGA's to improve practice systems for cervical screening according to national guidelines.

Through the project and targeted effort in practices in the Wollongong and Shellharbour LGAs, we have provided 1,069 Pap tests and achieved the following (in the period 1 April to 30 September 2009) as shown in Tables 2 and 3.

Table 2 Target: Number and percentage of women screened who were previously unscreened or underscreened

Women never previously screened	64	(6%)
Women whose last screen was more than 4 years ago	156	(14.6%)
Women whose last screen was between 2 and 4 years ago	699	(65.4%)
Total number of women screened who were previously unscreened or underscreened (as described above)	919	(86%)

Table 3 Target: Number and percentage of women screened from targeted Culturally and Linguistically Diverse Background

Macedonian speaking	48 (4.5%)
Italian speaking	17 (1.6%)
Spanish speaking	3 (0.3%)
Other language	56 (5.2%)
Aboriginal and/or Torres Strait Islander	91 (8.5%)

If you would like some assistance, please contact Katherine van Putten, Cervical Screening Project Officer, Tuesday to Thursday, on 4220 7600 or email: kvanputten@idgp.org.au.

Louisa Raft
Project Manager

Sources:

(a) Alam N, Banks C, Chen W, Baker D, Kwaan G, Bishop J. Cervical Cancer Screening in New South Wales: Annual Statistical Report 2005. Sydney: Cancer Institute NSW, January 2008.

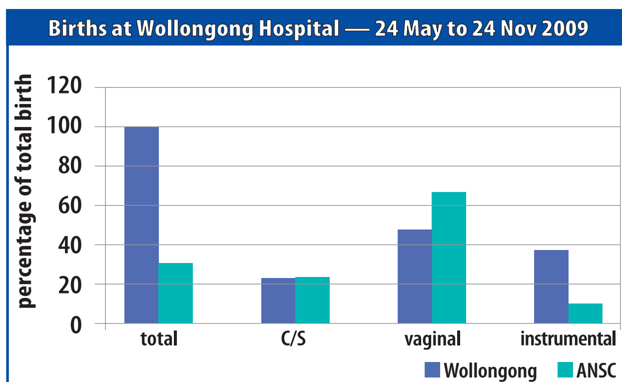
(b) NSW Cervical Screening Program. Annual Statistical Report 2004. Cancer Institute NSW, Sydney, 2007. (

c) NSW Cervical Screening Program and the NSW Pap Test Register. Annual Statistical Report 2003. Cumberland Hospital, Sydney, 2005.

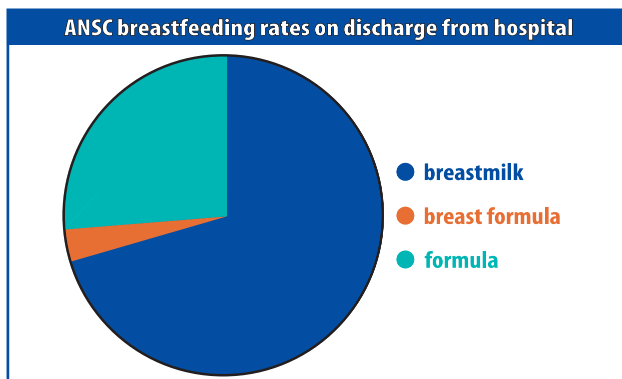
Cleared for **Landing**

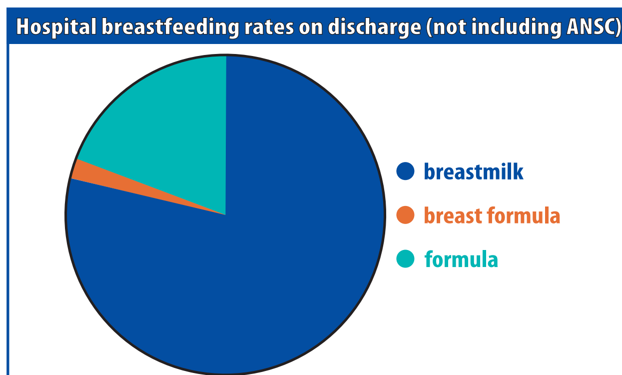
The ANSC program has been running for over 13 years and has made a considerable difference to the provision of flexibility, choice and continuity of care for Illawarra's antenatal women. In this article, Leanne Cummins looks at the highs and lows of the Antenatal Shared Care Program

The Antenatal Shared Care Program currently has 366 women registered from 52 practices. These women make up just over 30% of all antenatal clients booked into Wollongong Hospital. The following diagram demonstrates that we have a fantastic vaginal birth rate which reflects the excellent preparation they receive from their GP.



However, ANSC breastfeeding rates on discharge reflect that our women may require additional information and support. The following diagrams indicate that we are well below the hospital breastfeeding rates, and not even close to the National Breastfeeding Strategy's recommendation that 80% babies be exclusively breastfed at six months.





Changes to booking women into hospital

Wollongong Hospital's booking-in system has changed for all antenatal clients. All patients must now present to the admissions desk on Level 1 Block A of the hospital PRIOR to making an appointment in the antenatal clinic (bookings ph 4253 4256). The antenatal clinic is closed for lunch 12-1.30pm.

As a result of having to physically present to the hospital, more women are booking into hospital after 18 weeks gestation. If you see a woman during early pregnancy and refer her to the hospital, it would be appreciated if you could let the ANSC coordinator know to expect your patient (and track her visits with you). See below for phone, email and fax details.

Program Updates 2010

- Wednesday, May 12, 6-9pm. Peri and postnatal depression with case study by Gidget Foundation
- Saturday, August 14, 1-4pm – Medications in pregnancy and lactation with case study by Mother Safe

If you have attended an Antenatal Update in another area, please let me know so that your records can be updated.

Clinical Pathway

A clinical pathway exists for all GPs and was last updated March 2009. The pathway recommends tests and visits for your antenatal clients. Please contact me for your up-to-date copy if you have not picked one up from an Update this year.

Leanne Cummins
Fax 4253 4257, Ph 4253 4271,
email: Leanne.Cummins@sesiahs.health.nsw.gov.au

Taking it to the Streets

We asked three local GPs to answer the question, "What do you think of the Rudd Government's reform proposals?"

Dr David Grant —

The general thrust of Rudd's Health Reform is in improving access and equity to all health services in a timely fashion for those most in need and disenfranchised, this is to be done via strengthening Primary Health Care (PHC) Services and in particular General Practice.

It would be churlish and even stupid of me as a GP to argue against these welcome changes of direction and I am particularly excited by the idea of a person controlled electronic health record for each Australian and paperless, seamless communication between all health providers as a much needed vault into the 21st century for Medicine.

Making the one level of Government responsible for all Public funding and policy for PHC is absolutely paramount to this aim. The proposal is top heavy on rhetoric and remarkably light on solid information on how to achieve this.

Dr Steve Lyon —

I think it is a positive move towards improved collaborative and integrated primary care and it really only consolidates what has been happening in a lot of general practice already.

As long as general practice is at the front and centre of patient care, there may not be a very noticeable change to the way most GPs practice.

If they are implemented well, to the extent that was outlined in the National Health and Hospitals Reform Commission, then it will likely produce a significant improvement in patient care and hopefully enhance the health of the wider community.

I'm less enthusiastic about the Comprehensive Primary Health Care Centres, which if too large, may erode the important family-friendly feel of good general practices and also reduce continuity of care.

Dr Jenny Smiley—

I would support the Rudd Govt initiatives to encourage nurses into general practice but strongly oppose any moves to have nurses in pharmacies or the giving of vaccinations in pharmacies – who will be trained and available in case of anaphylactic reactions?

The Pharmacy Guild has strongly held onto the philosophy of only having pharmacists owning pharmacy licences on the basis of them not having a financial interest in selling medications as opposed to Drs owning pharmacies – if pharmacists are now to employ nurses and give vaccines then surely doctors should be able to own pharmacies – pharmacists cannot be allowed to have it both ways – fair go!

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