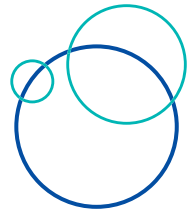
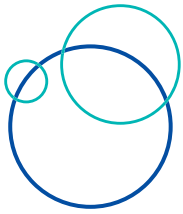


# Trilogy



**Illawarra Division of General Practice  
governance ~ practices ~ community  
Autumn 2010**

**catharsis health reforms reflections  
taking it to the streets electrons behaving badly**

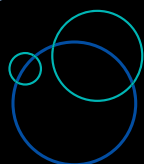


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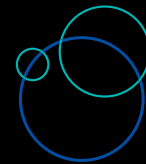
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# Catharsis

## Accreditation support for members

The IDGP provides comprehensive assistance to support practices through the accreditation and re-accreditation process.

Having a database of practices and their due dates for re-accreditation means that pro-active support can be provided. Mock accreditation visits are available to practices. Information on accreditation standards and processes is provided to practices by phone, email or practice visit. Resources are available for download from the IDGP website [www.idgp.org.au](http://www.idgp.org.au).

Education workshops on important aspects of accreditation such as infection control and triage are held. Small group education can also be provided on-site.

Individualised assistance to develop practice policy and procedure manuals or to complete Accreditation Pro or GPA+ can be provided.

## Home Nurses Add Health Option

Royal District Nursing Service (RDNS) has expanded its service to Illawarra. One of Australia's oldest and most respected nursing organisations, RDNS delivers a wide range of professional nursing and healthcare services to people in their homes or other places of their choosing. The service is available 24 hours a day, every day.

RDNS is also contracted to provide home nursing and personal care to war veterans (including war widows and widowers). The organisation has a long history of working productively with General Practitioners.

To find out more about how RDNS can assist with your patients' care, call their health

professionals' line on 1300 NURSING (1300 6877464) or visit [www.rdns.com.au](http://www.rdns.com.au)

Lifestyle management program (LMP) In an effort to reduce the incidence of Type 2 diabetes in the Illawarra, IDGP is expanding its "Reset Your Life" lifestyle modification program. Consisting of seven sessions, the program runs for six months and provides lifestyle advice from an exercise physiologist (Lauren Hickson) and a dietitian (Anita Needham) targeting those aged 40-49 years at risk of diabetes.

Patients in this age group should complete the AUSDRISK tool (<https://www.ausdrisk.com/>), and those who score 12 or above should be referred to the program using the LMP referral form.

The Division is able to assist practices in developing the best method to capturing this population group to implement the AUSDRISK tool and subsequently refer to the program. For more information contact Lauren on phone 4220 7600.

## Heart failure service in the right place

The Heart Failure Service has moved to the Port Kembla District Hospital. Services are unchanged. The unit is contactable on 42238413.

Commercial licences for diabetic patients It is a requirement for people with diabetes who hold commercial licences or trucking licences or work for the railways etc to have an endocrinologist certify that they are fit to hold this occupation and/or to continue with their current licence.

This is a significant legal obligation and should not be undertaken lightly. The questions relate to overall control, hypoglycaemic events, compliance with treatment etc. For those patients attending

an endocrinologist, this information can be generated as a part of overall comprehensive care.

Patients who are not attending an endocrinologist are unfortunately often referred at the last moment, and with minimal information. In order to allow time to deal responsibly with the questions there will be inevitable delays and even expiration of the licence.

Accordingly, if patients are likely to require endocrine certification in order to continue with their occupation they should either bring at least three months of comprehensive glucose data and HbA1c results or be under the regular care of an endocrinologist.

## Refugee Health News

Regular outreach clinics are held throughout the year at Wollongong Hospital for refugee children participating in the SCH Walking Together longitudinal study. This study is assessing the physical health, development and psychological well-being of refugee children over the first years of settlement in Australia.

Dates scheduled for the remainder of the year are 13th and 27th August, 8th October, and 19th November. You are welcome to refer refugee children not enrolled in the study to these clinics.

Please contact Dr Janka Paprckova (SESIH Refugee Fellow) on 9382 8189 or email [janka.paprckova@sesiahs.health.nsw.gov.au](mailto:janka.paprckova@sesiahs.health.nsw.gov.au) to make a referral.

At the most recent Refugee Health Coordination Group meeting (3rd June), it was decided to ask GPs caring for refugee families to include Mumps serology and a request for BMI measurement, on all

# Catharsis continued



initial screening requests. Both SEALS and Southern IML have agreed to perform these two tests for no additional cost to refugee families.

Please contact Dr Vicki Wighton on 4274 1795, or Lisa Woodland on 9382 3309, for further information about on arrival screening.

## “Closing the Gap” in Indigenous life expectancy.

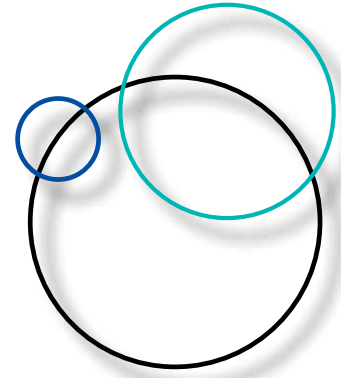
The Commonwealth Government has funded Indigenous Health Project Officers (IHPO) and Aboriginal Outreach Workers within a number of Divisions of General Practice. Their role will be to work with General Practice and the Aboriginal community

to encourage better usage of mainstream primary health care services by Aboriginal people and assisting General Practice to provide more culturally appropriate services. Linked with these positions is a new PIP Indigenous Health Incentive (IHI). There are three types of payments available:

- » **Sign-on payment:** a one off payment of \$1000 to practices that join the incentive and agree to undertake specified activities to improve the provision of care to their Aboriginal and Torres Strait Islander patients with a chronic disease.
- » **Patient registration payment:** \$250 for each Aboriginal and Torres Strait Islander patient aged 15 years and over, registered with the practice for chronic disease management in a calendar year.

### » Outcomes payment:

- » Tier 1 - \$100 to practices for each registered patient for whom a target level of care is provided by the practice in a calendar year.
- » Tier 2 - \$150 to practices for each registered patient for whom the majority of care is provided by the practice within a calendar year.



governance

## Education and Training Courses

**Southern IML Pathology**, the largest employer of pathology collectors in the Illawarra and South Coast is now offering the opportunity for external training with nationally recognised qualifications in HLT32607 Certificate III Pathology. This course can be taken as three weeks full time distance learning and education online at [www.southernpath.net/online](http://www.southernpath.net/online)

Certificate of Attainment available in —

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# A Season of Health Reforms

*Some have called the recent budget “The Primary Health Care Budget”. It certainly had more than the occasional reference to general practice and the Illawarra health landscape won’t look the same ever again. In A Season of Health Reforms, Andrew Dalley discusses the three major impacts as they may affect Illawarra general practice.*

governance

governance

The process of establishing a **headspace** site is long, complex and expensive. So it will not be surprising if the 30 additional **headspace** sites funded in the budget are allocated as additional sites to most of the existing **headspace** providers. Should this prove to be the case, the Board will have to decide the most appropriate location for such a site. The existing site currently houses not just headspace but also outreach services from Relationships Australia, The Access Community Group and the Drug and Alcohol Service SESIAHS. It received 60 new referrals on average each month and provides an average of 10 services per client – a complex population indeed.

Whilst the superclinic (Shell Cove Family Health) is an obvious possibility for a second site, there are other sites both north and south which would benefit the local population. Headspace currently runs outreach services in both the northern and southern suburbs and further funding would help consolidate those services.

However, it is the advent of Primary Health Care Organisations (PHCOs) which is raising a few eyebrows. The former Prime Minister seems to be a lone voice calling for PHCOs to be called Medicare Locals. This would mean that Wollongong would have a local Medicare office and a Medicare Local office. Most appealing.

AGPN is suggesting that PHCOs should be constituted as new companies and that membership be made available to organisations alone, for example Local Government, Aboriginal Medical Services, Universities, etc. GPs would have to be represented by their own group which would have to be formed unless the Division survives in some smaller format.

A few voices have objected to this scenario, if only from a corporate governance perspective in that it could be difficult that a public company such as ours should seek to replace itself with an unrelated company whose members were vastly different to that designated by our

constitution. AGPN has contracted an external report to advise where boundaries of PHCOs should be determined. In that report the Illawarra has been associated with the Shoalhaven area. It is highly likely that this will be the final boundary but we won’t know finally until December 31st; the date we will also know the boundaries of Local Hospital Networks. Whether we will be able to negotiate that boundary is as yet uncertain.

Expressions of interest will go out for Divisions to nominate to form one of the first 15 PHCOs by July 1st 2011. In any event, there will be no more Division-specific funding after 30 June 2012 at which time all PHCOs are expected to be in operation. Only Divisions that have demonstrated their capacity to do so will be invited to form PHCOs, subject to member agreement.

The work of PHCOs will vary significantly from that of the current Division. Though not in the Budget, most Divisions are determined to maintain

current levels of practice support, though these services will need to be extended to cover all practices, not just general practices. From 2013, there will be specific funding to provide afterhours medical services to the community. However, the early work of the PHCO will be to assist the marginalised (in our area that could include refugees, displaced children and Aboriginal persons) and those at high risk of hospitalisation (eg people at risk of falls-associated injury, COPD, diabetes and heart failure).

The third impact will be the advent of Local Hospital Networks (LHNs). The current Area Health Service sizes are generally regarded as grossly oversized and PHCO engagement with a smaller LHN should improve clinician care of patients presenting to or from local hospitals.

In any event, a remarkable season of health care reforms.

**Andrew Dalley**

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## In your 17 years with IDGP, what changes have you noticed for the better in Illawarra general practice?

The most obvious one is the increasing collegiality of GPs. The 1980s was a decade of relative oversupply of GPs and there was a sense of competitiveness in general practice that has virtually disappeared. GPs are also, in my opinion, more important to the community than they were 17 years ago.

Indeed, medicine is more important in general because so much more can be done for patients. The shortage of GPs has contributed to their rise in status. Getting a GP is now more important than getting a cardiologist. Practices are now much bigger than they were 17 years ago and that's due in part to younger GPs being unwilling to invest in practices and therefore seeking employment in existing practices. It's also due to a huge rise in the number of nurses in general practice which has become a valid career option for nurses.

We shouldn't ignore the upside of the GP shortage in that many GPs have decided

to delegate clinical responsibilities to nurses, or registrars or even medical students. Nurses are enjoying a greater clinical role and most GPs have found them indispensable in managing the chronically ill as well as the acutely ill.

## Do you think the Illawarra is unique in having a GP shortage?

For a region so close to Sydney we are somewhat unique. The Commonwealth has long provided relocation incentives for GPs to move out of the Illawarra to the Shoalhaven in the south and to the Southern Highlands in the west under the rural incentives scheme. Incentives even apply for GPs to move to Heathcote and Sutherland in the north under the Outer Metropolitan program. Apart from Kiama, the Illawarra is too rural to be outer metropolitan and too metropolitan to be rural.

## Obviously not a marginal area. So any changes for the worse?

In my opinion, the advent of corporatised general practices has been an adverse outcome. Traditionally, general practices have stood out as community institutions renowned for their altruism. It's hard to make that claim for practices driven by market expectation. That doesn't necessarily change the quality of services, but it does change perception.

I also struggle with the concept of government rewarding process as distinct to outcomes. As a colleague once said to me, there is not a close association between placing signs on toilet doors and better patient health outcomes.

Classically, the ultimate loss has been deskilling. GPs have moved out of Illawarra hospitals in droves. When I first came to the Illawarra as a medical student much of the surgery and most of the anaesthetics and obstetrics was done by GPs.

We all bemoan that loss whilst wondering where on earth we found the time to do all that in-patient work.

## What hasn't happened that should have happened in the Illawarra?

Now that's a bold question. Three things haven't happened that should have. I would have liked to have seen the Radio Doctor Service, which provides a critical service for its members, take the next two steps. The first step would be to move from a home visiting service to a clinic based service with the opportunity of providing better care (as reported in the world literature) and more complex care. The second step would be to cover the whole Illawarra.

Secondly, we have failed to support our female GPs who, according to our data, often struggle with delivering complex care to their patients. One of our surveys indicated that female GPs are 8 times more likely to lack confidence in treating patients than their male colleagues. My guess is that female GPs are more likely to dig out problems that we males often overlook or ignore. Just a guess.

Thirdly, we have left our consultant colleagues behind. Many still work in small cottages and in isolation. They face the same business challenges that general practice faced 15 years ago. I have some regret that the Illawarra Medical Association which embraced GPs and consultants, has passed into history.

## What do you see were the big changes that the Illawarra has experienced over the last 17 years?

Good question. The first one is easy and it may be surprising; GST and the BAS. The BAS revolutionised general practice. Almost overnight local accountants stopped getting shoe boxes crammed with receipts. GPs started reorganising their lives and discovered electronic finance reports and the rest was history. The BAS brought about what was perhaps the biggest change general practice has ever seen.

The GSM has also wrought huge changes to the Illawarra, not so much because practices started taking students but because GPs were at last recognised for their potential as clinical teachers. In 1993, no one would have suggested that one day Illawarra would have half a dozen GP Clinical Associate Professors and many more Clinical Lecturers and Senior Lecturers.

The Division's activities in practices is the third. In any year, almost all Illawarra practices seek the support of our Practice Support Team and the majority of practices are customers of OTiS. It's hard to see how some practices would have coped without such support.

## Ok. So that's the past tidied up. What changes is Illawarra general practice yet to face, in your opinion?

Glad you asked. There are a few. General Practice is about to become the focus of more intense and complex teaching. Many GPs are taking GPRs and medical students together but it won't be long before they will be asked to take trainee nurses and

invited to take PGPPP doctors (the ones we used to call RMOs).

Already, over 60% of lecturers with the GSM are GPs and most of those are unpaid. But teaching will occupy a very significant role in general practice and we will have to learn how to adapt to that role as education becomes institutionalised in general practice. The Commonwealth should, as a matter of urgency, determine how general practice can be supported in this critical role.

PHCOs have recently been announced. Current modelling suggests an amalgamation between Illawarra and Shoalhaven Division areas with broadening of membership to include allied health providers. Changes shouldn't be huge for GPs. Local Hospital Networks are also on the horizon and they should work more closely with GPs than the current system has.

Perhaps the most important change is the trend for GPs to move away from owning practices. Many GPs will prefer to work in practices rather than manage them and to be able to retire whenever they choose.

A local PHCO will need to factor this into its strategy.

## By 2007 you were working full time as IDGP CEO. Prior to that you were a part time GP in Nowra. What was it like belonging to another Division of General Practice?

A truly perceptive question. The most obvious difference between Shoalhaven and Illawarra Divisions was the sense of collegiality between GPs and consultants. Perhaps because of size they work much more closely as a profession in

Nowra. Shoalhaven Division has access to MAHS (More Allied Health Service) funding which allowed them to provide allied health services directly in general practices.

Not all Shoalhaven GPs welcomed this initiative (though many did) as there were strong economic drivers to rent additional space or to use it to train medical students rather than just make it available to visiting allied health staff employed by the Division. This will be relevant to us as we plan the introduction of new Diabetes services and now that Kiama Municipality practices have been rezoned as rural.

## Finally, what do you see as the Division's greatest achievement in your time as CEO?

Easy. The **headspace** practice. And not just because it provides superb care to hundreds and hundreds of young people, which it does and of which I am particularly proud. Partly, because under Louisa Raft and more latterly Christine Comber, it has devised a multidisciplinary team approach to care which is heavily GP supportive. It's a model we'll be building into the superclinic. The third reason is that **headspace** has captured the imagination of the community and we are looking at well over \$100,000 in donations coming in from the community to extend our range of services. In particular, we recognise the Tobin Fund which has seen **headspace** in Schools as an important investment for them.

## Last words?

Yep. Thanks to the many GPs who expressed their support in the hard times. It's a truly great profession.

# The West Wing

*The Board has a broad range of directors one of whom is Angela Mason, a Fellow of the Australian Association of Practice Managers, past National President and Director with over 30 years experience in health care. Angela is a Registered Nurse with post graduate diplomas in management and training, Diploma of Practice Management and she is currently enrolled in the Corporate Directors Diploma. In The West Wing, she tells about herself, her role as a director and her view on general practice*



My mission is to empower health care providers to succeed in and enjoy the business of medicine.

As a highly sought after consultant I have travelled all over the country setting up practices, teaching practice staff and improving established practices in rural and remote areas as well as in our cities.

I have and continue to work on an assortment of health committees and boards including Medicare, Divisions of General Practice, Colleges, Universities, Insurers, Professional Organisations, Aged Care Facilities, Accreditation Bodies and Software Designers.

My major accomplishments are completing the Kokoda Track in 2009 and raising over \$10,000 for Leukaemia, being nominated for Australian Small Business Woman of the year in 2000, 2001 and 2009 and raising two great kids.

The Illawarra Division of General Practice is one with clear goals, great leadership and supportive structures. I feel privileged to be accepted as a board director and bring a passion for efficient, effective and professional management in General Practice that will improve the health environment, enhance the service to patients, reduce risks of adverse events and keep practitioners financially viable.

My expertise is in developing practice systems, training and motivating staff, financial monitoring and implementing good, positive communication strategies.

We don't know what exactly is in store for general practice but we do know that changes are imminent and will be significant, the model will be a collaborative one pushing for a team approach to improving patient outcomes. Supporting general practice in this constantly evolving model is imperative; I know the practicalities, I am enthusiastic, I have the skills and I am absolutely committed to really help.

**Angela Mason**

*After many years of strident consumer representation Helen Gapps has retired leaving the way for Patricia Noferi to move onto the board and to undertake the role of Chair of the Consumer Consultative Committee. In West Wing Patricia, one of our most recently appointed Directors, answers some astute questions about her approach to primary care and directorship.*

## Welcome to the Board, Patricia. Where have you been all these years?

I was appointed to the board as the culmination of my membership of the CCC to which I nominated four years previously, representing the Cultural and Linguistically Diverse (CALD) portfolio. My background has been in nursing and small business.

Recently working as the RN coordinator of a CALD dementia day respite service I often advocated for clients and carers and provided access to support services.

Life experience has also involved situations where I have challenged private health insurance and obtained better outcomes for my family and others.

## One of the roles of the Division is to advocate on behalf of GPs. What is your view of GPs from a consumer perspective?

GPs provide an essential service to people for a healthy life, and entry to the health care system. They deal with the whole spectrum of health and illness; coordinating patient care, having continuing interactions with patients, and fulfilling a role as 'physicians of the soul'. It is important that people have timely and consistent access to GPs. Already the development of multidiscipline, integrated practices is becoming the norm. I think that the role of general practice will increase as primary care becomes more significant in the management of chronic disease within the community. Political change is in the wind.

## How do you see your roles on the IDGP Board as well as the Consumer Consultative Committee?

As a retiree I have adequate time to do justice to the position of being chairperson of the CCC and a member of the Board reporting on the activities of the committee – comprising eight representatives from various sectors of the community. I hope to be able to adequately reflect the views of the committee to the Board and I also wish to make the general community more aware of the programs of the IDGP.

**Patricia Noferi**

# The West Wing

*The Board's most recently appointed Director is medical student and student member of IDGP, Mary–Therese Wyatt. Mary–Therese is a final year medical student at Wollongong University. In The West Wing she discusses her past and her hopes for the Division's future.*

Prior to my studies in Medicine I had a range of career experiences. I graduated from Wollongong University in 1997 with a Bachelor of Biomedical Science and worked for some years in the pharmaceutical industry. I later completed my Postgraduate Diploma of Education in Mathematics in 2000 and worked as a Mathematics teacher in both Wollongong and country areas of NSW.

I realised my passion for health care and General Practice whilst living in the country town of Tamworth, where I realised the need for more doctors to service our rural and regional areas. Since starting my studies at Wollongong University I have been involved in promoting General Practice as a career

option through my association with the General Practice Students Network (GPSN). GPSN is a national student interest group that organises functions for students with a General Practice career focus.

I have been involved both locally and nationally with this organisation and was National Secretary of GPSN in 2009. In 2009 I also became involved with the General Practice Registrars Association and was elected the student board member of this association.

As a newly appointed board member of IDGP I would hope to bring a student perspective to the board and continue to foster good relationships between the next generation

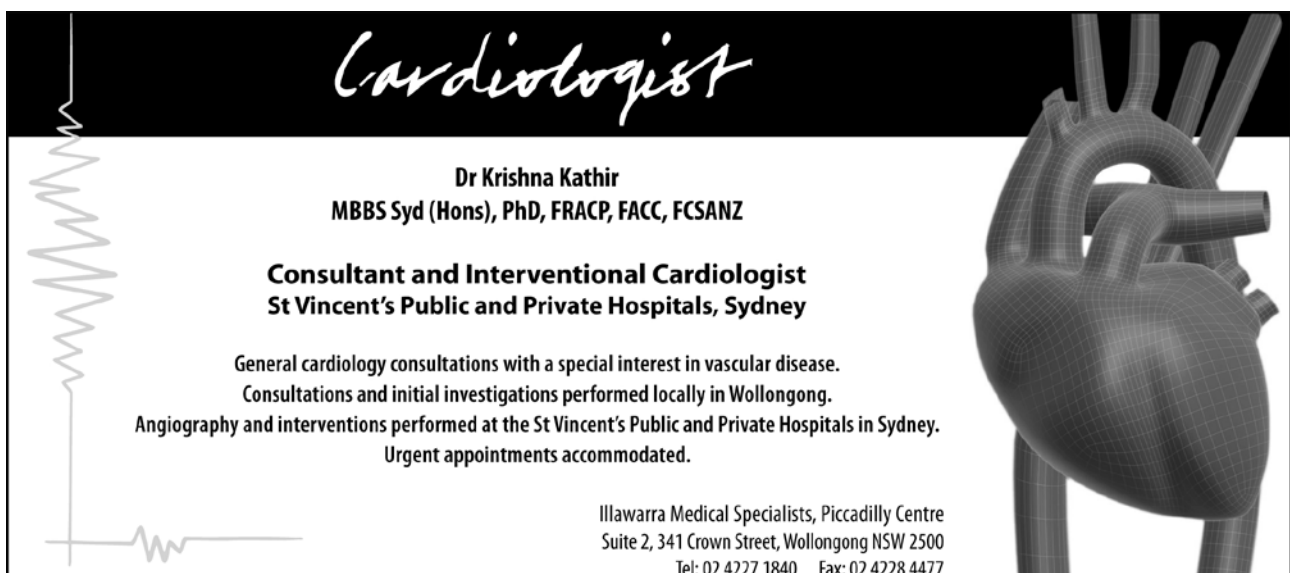
of General Practitioners (medical students) and the Division of General Practice.

I am abreast of current issues in training of General Practice through my prior association with GPRA and GPSN. As we enter a new era of health reform and increasing numbers of medical graduates I see General Practice undergoing a time of exciting change which should cement General Practice as the corner stone of health care.

I look forward to being involved with programs at the Division that benefit the health care needs of residents in this region.

**Mary-Therese Wyatt**

governance



*Cardiologist*

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# What Goes Down



*Home Medication Review (HMR) made its debut in the Illawarra 7 years ago. For most of that time, Pharmacist Karina Bronska has inspired GPs to undertake this important role in conjunction with local pharmacists.*

*Routinely Illawarra is in the top four performing Divisions in Australia based on the number of HMRs conducted. Commonwealth budget considerations have meant that Karina will be leaving us. Whilst we will all miss her quiet professionalism, none will do more so than Margaret Jordan with whom she and Karina, have presented a professional and industrious service to our members and therefore to their patients.*

*In this, her last article for Trilogy, Karina reminds us that warfarin is a wonderful drug for mishaps and INR calamities. In What goes down, Karina, recounts some blood curdling experiences and then reflects on her blood curdling time with IDGP.*

practice support

By far the most common culprit of unstable INR is low compliance. Patients will often admit to “sometimes” forgetting to take their warfarin. Numerous studies have shown that admission to occasional forgetting indicates generally low compliance.

Ticking doses off on a calendar or using a weekly dosing aid (filled by the patient) may sometimes remedy this. If night time dosing is a major problem, dosing the warfarin in the morning may resolve this. Warfarin is only dosed at night as the blood test is done in the morning in order for the INR results to be available before their next dose in the evening.

For a dose of 4mg or 4.5mg, several patients have been found to be cutting off the corner of a 5mg tablet. Needless to say their INR was not stable.

Sometimes patients mistake the advice regarding their INR and warfarin dosage given to them on the phone. This has sometimes resulted in taking doses of say 2.5mg where it was the INR that was 2.5. This tends to be a problem in patients early in their warfarin therapy.

Occasionally patients get very confused about what milligrams are. This may result in patients taking 5 x 5mg when the dose is 5mg or not being able to total 7mg using 2mg and 5mg tablets

as they perceive that the “mg” is some sort of conversion factor. In such cases, comparing the 1mg, 2mg and 5mg tablets to money has sometimes helped patients understand the simple addition needed to make up their dose. Alternatively, prescribing only 1mg tablets makes it simpler.

Food interactions account for many INR mishaps. Patients admit to eating whatever green vegetable is in season in their backyard: spinach, brussell sprouts, broccoli. This problem may not be obvious all year round, just when such vegetables are in season; also patients may eat large portions as home grown vegetables should never be wasted.

Complementary therapies are being used more and more often by the older patient. Most commonly fish oil, ginkgo biloba and ginseng will increase bleeding risk. It is important to note that this may occur without affecting INR, especially with fish oil.

A long term warfarin patient with a stable INR lowered his warfarin dose himself when going on twice yearly cruises as this allowed him to indulge in more beer than he usually has at home.

Even when warfarin is packed into websters by the pharmacy, this does not ensure that it is actually taken. Recently the

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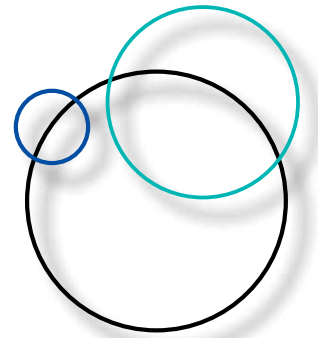
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# What Goes Down



warfarin dose of a gentleman was being increased regularly as his INR was always too low. Eventually the patient confessed to not taking the warfarin. He had a nice stockpile in a jar at home.

This was because he bled a lot after a fall and his neighbour had told him it was because of the warfarin. So he stopped taking the warfarin because he was scared if he fell again he would bleed to death. A nurse now administers his medications from the webster twice daily.

A gentleman caring for his wife had been using old and empty Coumadin bottles to store all of her other medications for easy administration.

There were 14 Coumadin bottles lined up on the kitchen table when I came for the interview, all of which had some obscure marking indicating what drug was actually inside.

Of course, warfarin 1mg,

2mg and 5mg were in there somewhere also!

HMRs can tell many wonderful stories. They started in the Illawarra in 2003 with 13 GPs referring patients. Seven years later we have 75 GPs referring 1731 patients a year (2009 Medicare statistics) for a Home Medicines Review. The program has been successful nationally and the recent budget announcements have confirmed continuation for HMR funding.

Unfortunately, HMR facilitators at local Divisions of General Practice which support the HMR process as well as providing community and pharmacist education have received no further funding in the new health budget. The federal government contract for facilitators ends at the end of June.

Recently, a third year medical student accompanied me on HMR patient visits. This is what he had to say about his experience with HMR;

“Overall, I feel that the Home Medicine Review Program is of significant benefit to the patients, as well as health professionals involved in their care.

The program helps to identify issues in medication regimes, which might otherwise be overlooked. Addressing these issues can only improve patients’ health outcomes.”

This student was interested in the patient–pharmacist interaction and the way the information was gathered from clues relating to the patients’ health in conversation and by observing the home environment.

I can say with confidence, HMR in the Illawarra will continue to help GPs in patient care and will empower patients in understanding their medications.

**Karina Bronska**

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# Under the Microscope

*Many GPs don't get to see the Practice Support Staff ferreting away in their rooms. In bringing a record year Under the Microscope, Practice Support Team Leader, Linda Blackmore, reports on sometimes cryptic, but always effective service.*

"We were really happy to hear from you so soon. Thank you so much for the patient feedback surveys. They look very professional. Also thank you for the quick reply regarding the pamphlets. As always you have been a great help and we regard ourselves as very lucky to have your help." (Practice Manager).

Over the past 12 months we have recorded 1246 occasions of service, significantly exceeding our target of 500 occasions of service. We provided at least one occasion of support to all 86 practices in the Illawarra Division, with 72% of practices receiving a practice visit.

The areas that general practice received the greatest level of support for were: Accreditation (247 occasion of service), Medicare (188 occasion of service), immunisation (167 occasions of service) and information management (202 occasions of service).

To provide greater support for local practices in priority areas, the Service has developed service packages for accreditation and information management which provide focused support to general practices. The

Practice Support Service is developing an immunisation package that will be available to Illawarra practices in the coming months.

"Would you please give a big thank you to [those] involved in arranging the Profile training session last Saturday. [We] found the day to be very beneficial and only whet our minds for more information. The content of the day was extremely useful. Thank you again for arranging it at the Division. Maybe another session can be arranged down the track again." (Practice manager)

A total of 73% of practices attended at least 1 education event organised by the Practice Support Service. 23 education workshops and 10 onsite education sessions were held. A key feature of the Practice Support Service's education program is the provision of education for practice nurses: in total over the past 12 months 72% of nurses attended education events, exceeding the Division's target of 40%.

The Service has provided additional resources to support practice managers and 32 practice managers have attended our quarterly Practice Managers Forum.

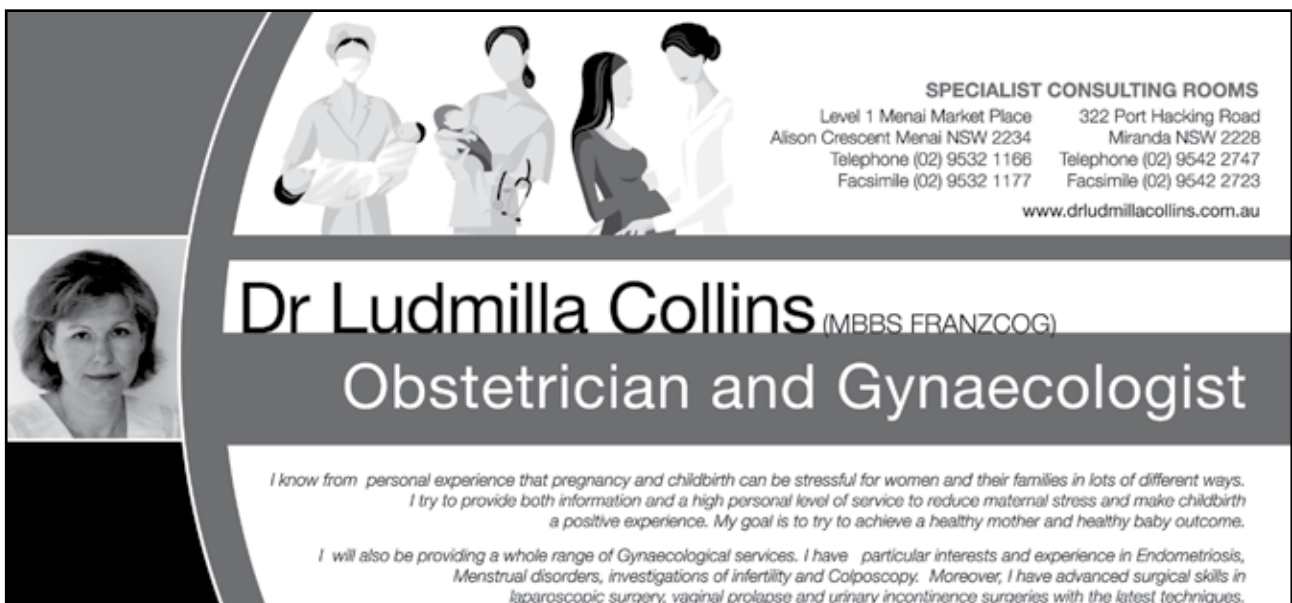
The cervical screening project has achieved impressive results and has also met its targets. Over the past 12 months 1,352 Illawarra women have had a pap test and 84% of these were previously unscreened or under-screened.

Closing The Gap commenced early in 2010, with the aim of improving access to primary care services for Aboriginal patients. The Indigenous Health Program Officer is a source of information and support to local practices regarding accessing the new PIP incentive, utilizing the PBS co-payment and identifying and welcoming Aboriginal patients.

We look forward to working with all general practices over the coming 12 months. We are able to offer extensive support to practices as they move to the 4th edition accreditation standards and adjust to the new Medicare schedule.

**Your Practice Support team**  
**Linda Blackmore, Margaret Liackman,**  
**Chris Pitt, Kathy Lymbery, Katherine**  
**Van Putten, Brendon Fitzgerald,**  
**Alison Dunbar**

practice support



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**Dr Ludmilla Collins** (MBBS FRANZCOG)  
**Obstetrician and Gynaecologist**

*I know from personal experience that pregnancy and childbirth can be stressful for women and their families in lots of different ways. I try to provide both information and a high personal level of service to reduce maternal stress and make childbirth a positive experience. My goal is to try to achieve a healthy mother and healthy baby outcome.*

*I will also be providing a whole range of Gynaecological services. I have particular interests and experience in Endometriosis, Menstrual disorders, investigations of infertility and Colposcopy. Moreover, I have advanced surgical skills in laparoscopic surgery, vaginal prolapse and urinary incontinence surgeries with the latest techniques.*

# Taking Care of Business



*The new national industrial relations regime is now in full swing and by now you have most likely reviewed the terms and conditions governing the employment of your staff. This means ensuring your employment contracts and policies – written and unwritten – meet the minimum standards outlined in the National Employment Standards and in the provisions of any new Award impacting your practice. In Taking care of business, IDGP HR Manager, Nicola Bunt, outlines some key aspects of the changes brought about with the advent of the National Employment Standards (NES).*

## Flexible working arrangements

Employees who are parents or carers of children under school age, or a child under 18 who has a disability, and who have been employed for at least 12 months, have a legal right to request flexible working arrangements, for example part-time work, working more hours over fewer days or working from a different location (like from home).

This request can only be refused on reasonable business grounds which may include excessive costs, excessive disruption or impracticality.

The employee must make the request in writing and the employer must respond

within 21 days, also in writing. If the request is refused, the written response must outline the reasons why. A comprehensive policy in this area is recommended. The Fair Work Ombudsman publishes a Best Practice Guide on the right to request flexible working arrangements which may prove useful in the development and implementation of such a policy.

## Parental leave

Parental leave entitlements for staff who have been employed for at least 12 months are outlined in detail in the NES. It is worth noting that parental leave entitlements apply equally to male and female employees except for those clauses relating to pregnant employees.

Also of interest is that an employee on parental leave has the right to request up to an additional 12 months leave immediately following the end of the available parental leave period. Notice periods apply and the request can only be refused on reasonable business grounds.

## Personal/carer's leave and compassionate leave

Employees are entitled to:

- » ten days cumulative, paid personal/carer's leave, available when an employee is unfit for work due to illness or injury, or to provide care or support to a member of their immediate family, or

their household, due to illness or injury or an unexpected emergency.

- » two days unpaid carer's leave for each occasion when a member of the employee's immediate family, or their household, requires care or support due to illness, injury or unexpected emergency.
- » two days compassionate leave for each occasion when a member of the employee's immediate family, or their household, dies, or contracts or develops a life threatening illness, or sustains a life-threatening injury.

practice support

## IS YOUR PAIN MEDICATION CAUSING CONSTIPATION?

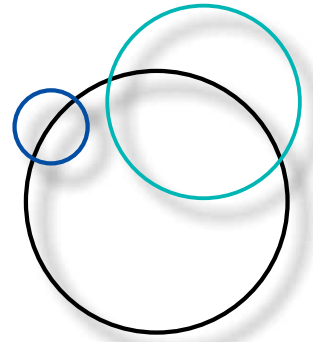
### Clinical Trial Volunteers Needed

**The Medical Research Unit, Port Kembla Hospital is conducting a clinical research trial to test a potential treatment option for people with chronic pain who experience constipation as a consequence of their pain medication.**

**We are looking for people who have:  
persistent pain that requires pain medication and are aged 18 years or older.**

**If you wish to find out more about this research project please contact a study co-ordinator, Port Kembla Hospital:  
ph: 42238206**

This project has been approved by the Hunter New England Human Research Ethics Committee



## Taking Care of Business continued

### Community service leave

Employees who engage in eligible community service activities, including voluntary emergency management activities and jury service, are entitled to leave for these activities. Employees on jury duty are entitled to be paid for up to ten days of their absence. All other community service leave is to be unpaid.

### Notice of termination and redundancy pay

Notice of termination must be provided in writing. Periods of notice for termination and redundancy pay scales are specified in the NES.

Redundancy pay is not payable to employees with less than one year's service, or for small business employers (defined as employers with 15 or less full-time equivalent employees). The Small Business Fair Dismissal Code outlines the special unfair dismissal guidelines for small employers.

### Fair Work Information Statement

Each new employee must receive a Fair Work Information Statement before they start employment or as soon as practicable thereafter. This is a statement outlining various aspects of their employment including the NES, modern awards, agreement making, termination of employment and individual flexibility arrangements.

The other four entitlements in the NES are

- (i) a maximum standard working week of 38 hours for full-time employees plus 'reasonable' additional hours,
- (ii) four weeks paid annual leave each year (pro rata),
- iii) long service leave; and
- (iv) public holidays.

This is a very brief introduction to the National Employment Standards. Further information can be found in the references provided. The Practice Support team is also available to provide advice and point you

in the right direction as you work towards implementing these new standards in your Practice.

### Some useful references

Best Practice Guide – The Right to Request (Fair Work Ombudsman)  
<http://www.fwo.gov.au/Best-Practice-Guides/Pages/Work-and-family.aspx>

Small Business Fair Dismissal Code (Fair Work Australia)  
<http://www.fairwork.gov.au/Termination-of-employment/Pages/Small-Business-Fair-Dismissal-code.aspx?role=employers>

Fair Work Information Statement  
[http://www.industrialrelations.nsw.gov.au/About\\_NSW\\_IR/National\\_IR\\_System/Workplace\\_information/Fair\\_work\\_information\\_statements.html](http://www.industrialrelations.nsw.gov.au/About_NSW_IR/National_IR_System/Workplace_information/Fair_work_information_statements.html)

National Employment Standards  
<http://www.airc.gov.au/awardmod/download/nas.pdf>

Nicola Bunt



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# Electrons Behaving Badly— Electronic Messaging: The Good, the Bad and the Ugly!

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

## Area Health Messaging

As many members are aware, the South East Sydney Illawarra Area Health Service decided to move away from the Illawarra-developed system of secure e-mail for the delivery of messages. The Area Health Service implemented Argus as a secure messaging system across the Area, we were not involved in the selection process for the secure messaging solution that the SESIAHS decided to implement. The SESIAHS gave GPs two options for receiving Docmail and the new Electronic Discharge Referrals, via fax or Argus.

If anyone is having problems receiving Docmail or EDRS messages either via Fax or Argus, you are welcome to pass the issue to the OTIIS team for us to follow up with Area Health or Argus, contact details: [otiis@idgp.org.au](mailto:otiis@idgp.org.au) 02 42207699

A large percentage of Illawarra GPs currently have Argus installed; these GPs are primarily set up to receive incoming electronic messaging via Argus. The IDGP has installed Argus for no charge to interested GPs. Up to this point Argus has not levied any compulsory fees for the use of Argus from GPs.

## Receiving reports from consultants

GPs who currently have Argus are able to receive reports from other health care providers via Argus. IDGP plans to do a mail out to Consultants advising them of the high number of GPs able to receive correspondence via Argus and outline the benefits of secure messaging between consultants and GPs.

If practices are keen to receive correspondence from consultants via Argus it would be a good idea to advise the consultants used of your preferred method to receive correspondence.

One way to keep consultants informed is to put some information in your referral template advising consultants that you would prefer to receive your correspondence via Argus to reduce the scanning and paper handling in your practice. In addition, by reducing your scanning you will reduce the speed that your clinical software storage needs grow and in doing so you may reduce the amount you need to spend on IT infrastructure.

## Argus 5

Argus 5 is the latest release of the Argus secure messaging solution. The following is information provided by Argus on the new version Argus 5, full details are available from <http://www.argusconnect.com.au/view/latest-news>

### 1. Auto-online upgrades

Argus 5 includes the ability to automatically identify and download applicable upgrades and patches to assist with the maintenance and stability of Argus installed at your site.

All future Argus upgrades will be provided in this way. Only through upgrading to Argus 5 will you have this functionality.

### 2. Enhanced Argus Message Viewer

This Argus message administration utility has an improved interface for easier management of messages, acknowledgements, delivery failures and message reprocessing.

This utility also includes a status bar advising whether the site has an Argus Support Agreement and, if so, the expiry date.

### 3. Enhanced Argus Address Book Manager

This Argus address management utility has an improved interface for easier user interaction with the Argus Users Directory (AUD) for querying, viewing,

populating and managing address details of other Argus users with which practices communicate.

### 4. Interoperability with Medical Objects

Argus 5 will enable two-way clinical information exchange between Argus 5 and Medical Objects – connecting their combined user bases of over 20,000 health professionals in every state and territory of Australia.

## New License Conditions

The following is information provided by Argus Connect on Argus 5 new pricing structure, full details are available from <http://www.argusconnect.com.au/view/latest-news>.

Argus 5 will have new licence conditions and will not be released under a freeware license. Instead, the software license will be bundled with support on a paid subscription basis. The subscription fees will be assessed on the same basis and cost as the current Priority Support fees. Hence for a practice on Priority Support, the cost of using Argus will not change.

Current GP, Specialist and Allied Health Argus users that do NOT have a paid Priority Support and who choose to remain with their existing Argus 4 freeware license can do so. However, please be aware that Argus 4 will not undergo any further development and all support for Argus 4 will be phased out in mid-2010.

### Argus Connect charges for Argus 5:

Details are available from Argus Connect <http://www.argusconnect.com.au/content/support-options>

- » \$99.00 per full-time practitioner per year, instead of the standard price of \$121.00 (Full-time = 6 sessions or more per week)

# Electrons Behaving Badly— Electronic Messaging: The Good, the Bad and the Ugly Continued

- » \$59.40 per part-time practitioner per year, instead of the standard price of \$72.60 (Part-time = 5 sessions or less per week).
- » Capped at 12 practitioners.

## Unique Health Identifier (UHI)

The Federal Government appears has passed legislation to enable the creation of Unique Health Identifiers for users and providers of healthcare. I have been advised that this will be linked to patients' Medicare number and in time, practice clinical and billing software will be able to automatically retrieve UHI information.

There are many potential developments in e-health that the ability to identify users and providers of health care can enable. Like e-scripts, Shared Electronic Health Records, Personal Electronic Health Records and the electronic transfer of medical records between providers. For many years it has been recognised that one of the significant barriers to e-health is the inability to positively identify users and providers of healthcare.

## OTiS new help desk application

OTiS has introduced a new help desk application to help us manage the delivery of IT services to our customers. One of the main differences for practices will be the ability to log in to a customer portal and monitor the progress of outstanding jobs. We are very excited about the potential improvements to customer service the new software package brings to OTiS. If you are interested in looking at or using the customer portal please contact us via e-mail [otiis@idgp.org.au](mailto:otiis@idgp.org.au) or phone 42207699.

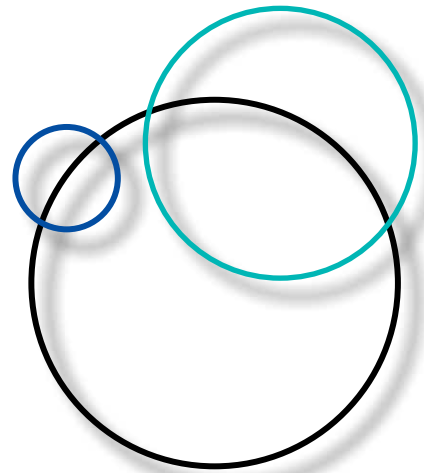
## New hardware sales website.

OTiS is currently developing an online IT sales website, where practices and practice staff are able to order hardware and software online. The web site is available

at [www.otiis.com.au](http://www.otiis.com.au). The aim of the new web site is to make it easier for OTiS to pass on savings and special pricing to practices. It is not a requirement that goods ordered through OTiS have to be set up or installed by OTiS. If practices are comfortable setting up their own equipment or have existing arrangements in place for IT support we are happy to provide the goods only.

Practice and practice staff are welcome to order from the online store for home or work. Please feel free to go to the site and have a look; any feedback would be appreciated. If you wish to order something please complete the 'Become a Member' registration form to order your goods. OTiS will review the order and contact the purchaser ordering the goods prior to placing the order with the hardware supplier.

Raymond Fitch.



### Advising Medical Practitioners of treatment available

#### Lymphoedema

**Complete Physical Therapy (CPT) involving a combination of manual lymphatic drainage, compression bandaging, home maintenance programs and compression garment referral.**

#### Low Intensity Laser Therapy (LILT)

**The clinic uses a Med 9 Acuderm Laser for the treatment of fibrotic lymphoedema, arthritis, musculoskeletal conditions and general pain relief**

#### Post operative oedema

**A combination of Manual Lymphatic Drainage and/or laser treatment to assist in the resolution of post operative oedema.**

#### Muscular Tension and Dysfunction

**Remedial massage specific to work, sport or general injury.**

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# Clinical Care —The Journey of a Mental Health Nurse Patient

*The IDGP Mental Health Nurse Service employs two full time credentialed Mental Health Nurses to support Illawarra GPs in the provision of holistic, coordinated clinical care for up to two years for people with severe mental health disorders and complex needs. In Under the Microscope, Mental Health Nurse Kim Capp presents a complex case study initiated by a local GP member.*

In August 2009, George was referred to the IDGP Mental Health Nurse Service and became a client of Kim's. Kim's introduction to George was by a phone call from a GP, who was concerned about a client who exhibited psychotic symptoms and requested an urgent appointment with the mental health nurse. The GP had assessed the risk, and as the patient had no past history of harming self or others, an appointment was organized for the next day.

George was in his late 30's, lived at home with family who were of Macedonian descent. At the first appointment George described witnessing an assault on a family member 17 years ago.

Since that time George has experienced auditory hallucinations, paranoia, anxiety, depression, and thought disorder. George now presents with fixed delusions about the assault and experiences ruminating thoughts, poor sleep and an inability to engage in everyday activities leaving him unable to work and develop relationships.

George described his mind as "being in a prison".

Kim described her role initially as "developing the therapeutic relationship between herself and the client. Once a relationship develops, a mental health nurse is able to support the client in working towards the client's goals."

After the initial assessment Kim discussed George's presentation with his GP. George was commenced on antidepressants and antipsychotic medication and an organic screen was performed to exclude any physical issues.

For the past six months George has been seeing the GP and Kim on a regular basis. George has been linked with a Psychiatrist and case conferencing has occurred between GP, Psychiatrist and Kim.

Kim has spent time with George's family providing education on healthy lifestyle, budgeting, psycho education, and general support on a range of issues.

There has been a definite improvement in his quality of life. George now feels more comfortably going out at night to clubs and feels more at ease in social settings. Kim and George have developed a strong therapeutic relationship which can continue under this initiative for the foreseeable future.

Service information: The IDGP Mental Health Nurse Service employs two full time credentialed Mental Health Nurses to support Illawarra GPs in the provision of holistic, coordinated clinical care for up to two years for people with severe mental health disorders and complex needs.

This service has been developed under the Mental Health Nurse Incentive Program and is a free service to meet the needs of people who are not acute but may be at risk of hospitalization.

Treatment can occur simultaneously with Psychologists at the IDGP Clinical Psychological Service under item 2710.

practice support

## Taking it to the Streets

*We asked Patricia Noferi 'How would you make hospitals better for GPs' and patients?'*

**At CCC meetings real concern and distress has been felt when a relative or patient has had a bad experience following admission to hospital and the accumulated knowledge about them by their GP, has not been utilized.**

**Unfortunately good information systems are not yet in place to treat the frail aged requiring emergency treatment, when their GP is not available.**

**Admission to hospital is often followed with more**

**unnecessary tests, a confused patient and a change of medications. When the patient is returned to their familiar environment – home or institutional care, one of the first things that a GP may need to do is to reinstate the original medication regime which has been tried and tested.**

**Therefore hospitals need to be more aware of the value of medication regimes already established by GPs. It is to be hoped that e-health when it is started, will help to remedy**

**this situation and create better transfer of documentation between institutions and GPs especially on admission, transfer or discharge.**

**This group of patients needs better access to trained practitioners with expertise in old-age medicine. Fortunately at the present time, some GPs and their clients, and carers already have systems in place for portable recordings of medical histories and medication regimes.**

# Under the Microscope

*Shell Cove Family Health is the name chosen for the GP superclinic by an enthusiastic group of Shell Cove residents. The emphasis on health reflects the focus on disease prevention and early intervention. In Under the Microscope, Lauren Hickson discusses the practices approach to teaching and chronic disease management.*

The Shell Cove Family Health resident group is excited about the concept of clinical teams lead by a senior GP and consisting of a second GP, a GPR, nurse, psychologist, EP and medical student. A less well developed team model has worked extremely well at headspace.

Opening day will see two teams in operation, moving up to three within twelve months. None of these positions will be full time, maximising flexibility of employment for clinicians but allowing for continuity of care for patients by providing consistent care within the team.

Realistically, much of the patient load will involve management of chronic diseases. The team nurse and medical student will play a crucial role at all stages of chronic disease management. They will prepare the draft GPMP which, having been reviewed by the GP, will form the basis of discussion at the first case conference which will define roles for each member of the clinical team and the patient and will determine a review schedule for the patient.

The case conference will identify co-morbidity risks. For example, most patients with stage 3 or 4 COPD have nutritional deficiencies. They will be lined up for review at the Nutrition component of the SNAP clinics (smoking, nutrition, alcohol, physical activity) organised by the team nurse. The team nurses will see their own patients (item 10997) to ensure care plan targets are being met. Variants will be escalated to the GP.

But the team nurse day starts and finishes with well women checks (item 10994) to allow working women the time to maintain their health. Like all clinical staff, her session is divided into blocks. She then moves on to review her chronic care patients; and an hour preparing patients for EPC items leaves the nurse a short period for clinical

interventions including immunisations, ECGs and spirometry.

Tomorrow's GPs, the GP Registrars who have been exposed to the model are particularly keen to see a career structure ahead of them. The most innovative of these is the Consultant GP (CGP), an attempt to recognise the complex work many senior GPs do that was once done by the general physician. Specifically, the CGP will participate in relevant Case Conferences, and they will also review all team patients' GPMP.

They will be responsible to review patients for Diabetes Risk Evaluation and for the 45 year old checkup and to inform the treating GP of findings or recommendations. The CGP will be available to manage emergency presentations and to see patients on referral from team clinicians.

Teaching is a central platform of each team and each team will have its own GP Educator (GPE). The GPE will be responsible to supervise GP Registrars and provide planned learning opportunities, they will conduct parallel consulting with medical students, and act as first point of contact for students.

They will be responsible for students as they assist the team nurse to conduct Health Assessments and GPMPs and for the quality of medical student work in SNAP clinics.

The GP Academic (GPA) role will partly subsume the GPE role but the GPA will also have a strong research focus. The third member of the education team is the Special Skills GP who will demonstrate specific clinical skills on a monthly basis utilising team patients charged under Medicare. Interest in this teaching role has been particularly high.

However, the backbone of the model is the GP. Patients with chronic illnesses who see the GP will all have seen the team nurse at

some stage to minimise red tape. Otherwise the role of the GP is not dissimilar to that of any other GP except that she or he will be able to directly book patients to see another team clinician (including the team nurse) at a specific time and a specific place (including a specific bed in the treatment room if necessary).

The subdivision on which construction of Shell Cove Family Health has recently commenced was registered April 1. Building time is expected to be 38 weeks with the facility opening in March 2011 allowing for the Christmas building shutdown.

Advertising for positions will occur around October with expectations of a healthy response both nationally and internationally as has been the case already at Geelong.

**Lauren Hickson**  
IDGP EP



# Under the Microscope

*In 2009 the Commonwealth released the National Gay Men's Syphilis Action Plan. The plan was needed as there has been an increase in syphilis and repeat episodes of infection in men who have sex with other men (MSM) across Australia. This trend is reflected to a lesser degree in the Illawarra and Shoalhaven. In Under the Microscope Dr Katherine Brown discusses patient management under the plan*

The key points of the National Gay Men's Syphilis Action Plan are to promote:

- » Screening for all men who have sex with men who haven't recently been tested
- » Screening for syphilis in HIV negative men every six months if they have frequent partner change (more than 20 partners in 6 months)
- » Screening for syphilis every three months in HIV positive men (at their regular review)
- » Notification of partners of men who have positive syphilis tests

indicative of recent infection

- » Active promotion of condom usage and education relating to the possibility of catching syphilis during unprotected oral sex as MSM rarely use condoms for oral sex.

Illawarra Sexual Health Service would like to encourage you to ask your male patients these two questions:

1. Have you had any change of sexual partner in the past twelve months?
2. Are your partners female / male / or both?

Illawarra Sexual Health Service is happy

to treat any patients with syphilis and to undertake the contact tracing required for this infection, which is notifiable to Public Health Units under the Public Health Act.

If you prefer to treat the patient yourself we are happy to provide advice if you need it. We can also provide a template for a contact tracing letter.

Clinical Associate Professor Katherine Brown 42238457 (Port Kembla clinic, daily) and 44239353 (Nowra clinic, Mondays).

*Most new parents find adjusting to life with a new baby very challenging. In Under the Microscope Louise Ramsay, one of the clinical psychologists working with the Clinical Psychology Service run jointly by Lifeline South Coast and IDGP, introduces the IDGP's PND Service.*

Over 15% of women and 10% of new fathers develop Postnatal depression. Many new parents do not know that PND can occur unexpectedly after delivery and typically blame themselves, their partners or their baby for the way they feel.

Some try hard to 'snap out of it' without understanding they have little control over the way they feel. It is very important that women, their partner and family's learn to recognise the signs and symptoms of PND so that they can ask for help.

What to look out for? This list is not conclusive but are symptoms identified by women who have experienced PND—

- » Sleep disturbance unrelated to baby's sleep
- » Appetite disturbance
- » Crying without apparent reason
- » Inability to cope
- » Irritability
- » Anxiety

- » Negative obsessive thoughts
- » Fear of being alone
- » Memory difficulties and loss of concentration
- » Feeling guilty and inadequate
- » Loss of confidence and self esteem

## Early Intervention is Crucial

Many women with PND say their feelings of stress and depression began during pregnancy. It is an important time to support the mental health needs of pregnant women to provide early intervention and prevention.

Pregnant women should be encouraged to access additional services to prevent ongoing depression after the baby is born.

## Service Operating Now— Who to refer:

Women, men and their families who are struggling with anxiety or depression in the perinatal period

## What is the perinatal period?

From conception to the baby being 12 months of age.

## What do you need to do?

Conduct a mental health assessment with the potential client and refer them to the division with a current mental health care plan. Sessions are fully funded under Medicare and there is no gap fee.

## What intervention is available?

Individual and group therapy is available. Group therapy for PND will be offered as one aspect of a woman's recovery, complementing other interventions that may be necessary. Women's learning about PND and themselves is enhanced within a group situation because they are learning from each other as peers.

If you have any enquiries please email Louise Ramsay on [lramsay@idgp.org.au](mailto:lramsay@idgp.org.au)



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### REPORTS

- Electronic downloads, on-line and/or hard copy
- Pathologist input and further test suggestions
- Urgent results communicated by phone or fax
- Easily interpreted colour highlighted results

### PATHOLOGY COLLECTION

- Placement of licensed collection centres (ACCs) within new or existing medical centres / practices
- Professional and experienced staff
- Pleasant collection facilities
- Home visits for non-ambulatory patients and clients at aged-care facilities

### SPECIALIST PATHOLOGY COLLECTION

- Collection and reporting of fine needle aspirations

### COURIER SERVICES

- Reliable, flexible and professional

### DIAGNOSTIC PROCEDURES

- Electrocardiogram (ECG's)
- Holter monitors
- 24 hour blood pressure monitors
- Spirometry

### PATHOLOGY SERVICES TO HEALTH AND AGED-CARE FACILITIES

- Comprehensive pathology and diagnostic testing
- On-site pathology collection and courier transportation
- "Copy to" reports delivered to site
- Electronic reporting available
- Flexible billing policy
- Infection control reports
- Educational sessions for nursing staff

### CONTINUAL PROFESSIONAL DEVELOPMENT (CPD)

- High profile speakers
- Current and relevant topics based on doctor feedback
- Educational clinics at clinics and nursing homes



For more information on Pathology South Coast and any of our services, including the placement of an ACC, please contact Roz Rhoads.

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