



biparietal

Quarterly Communicator of the Illawarra Division of General Practice - Summer Edition 2006/07

NEW!



INSIDE

On The Female Nerd

Florence Loses her Lamp

GSM - Precursor for Change

These stories and more inside!

Transitions *in general practice*

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Transitions

Biparietal is, in part, the Division's response to the death of GP News. It is a bifocal magazine, exploring local general practice in the two areas of clinical and business practice.


Each edition will have its own theme, "Transitions" being the first. For many of us, too many of us, considerations of transition are personal. Decisions about retirement and health are transition decisions. The GSM has offered other "transitions" and, as Susan Graham's article suggests, it also offers a transition role for patients. However, it is David Perkins who, in his lead article, typifies the transition of general practice into an important field of research. His scholarly work has identified a high incidence of smoking in pregnant patients using the antenatal shared care program. He has identified motivators for GPs taking medical students and GP registrars.

Transitions equally have involved the general practice itself in generally becoming larger and more sophisticated. A major change of the last decade, that of practice nurses, is addressed by Anne Harding. Helen Gapps explains the effect that an enthusiastic community group can have in the Illawarra in bringing about change. And Rob Mc Grath from the University of Wollongong presents some of his findings in examining GP attitudes to, and use of, information technology, in "The Female Nerd".

Transitions have also brought us to an era of commercialisation. The cost of Biparietal has been borne by its advertisers many of whom we have known for years and others are new and provide a broader array of clinical or business choice.

Indeed, many of us have known each other for twenty years or more. I hope that this edition, "Transitions", will allow you to pause and reflect on your practice, your patients and even your personal lives. I hope, too, that you will take pride in some of the great work being done in Illawarra general practice. ■

Andrew Dalley



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Research and Practice: Contribution or Distraction?

Research is slowly becoming part of the armamentarium of general practice to measure quality and to justify increased funding. Dr David Perkins, Director of CEPHRIS, has been invited to describe some of his unit's work in Illawarra and other general practices.

How many famous GP researchers can you name? Do you need one hand, two, or both feet as well to count them? I was thinking about this the other day as I was writing a research proposal to examine evidence about the primary health care workforce and one of our international GP partners sent me her CV.

It included heading up a new practice for patients rejected by other practices, publishing 70 peer reviewed papers and generating about \$8 million of research funds for research in primary health care in the last five years.

At the other end of the scale we have a small research group in the Illawarra called CEPHRIS, which is part of a larger University Research Centre at the University of New South Wales called the Centres for Equity and Primary Health Care. What have we contributed in our first three years? Modesty precludes boasting about achievements but there have been a number of interesting findings:

We discovered that the Illawarra Leg Ulcer Clinic serviced by GPs working with nurses could achieve clinical outcomes comparable with international best practice for patients with "unresponsive" leg ulcers.

We found that almost half of the callers to a Lifeline branch had levels of psychological distress which warranted specialist referral according to expert opinion, that about two-thirds were not currently receiving health care for their symptoms and that the same number thought that the GP was the best source of care for their problems.

We discovered that the provision of a clinical psychology referral service for GPs was attractive even when the GPs did not claim the MBS fee for their part of the care process and that patient symptoms showed significant improvement after six sessions of treatment.

A study of the shared care antenatal service has identified an important proportion of mothers who smoke during pregnancy with the attendant risks for the baby. We are currently seeking funds to see if it is possible to reduce this number so that some of our children get a better start in life.

A study of why GPs take medical students for extended (six months plus) placements was undertaken based on Australian and International evidence and demonstrated that the main motivators were personal and professional interest. Australian GPs found that placements needed to be well planned and supported and that active problem-solving was essential.

At the more academic end of things we are conducting a randomised controlled trial to see if an intervention to improve teamwork between GP, practice manager and practice nurse can improve patient outcomes in the care of patients with diabetes and heart disease.

The studies have different audiences and different objectives. They provide objective evidence about the impact of our activity. In some cases they provide evidence to audiences such as the Senate Select Committee on Mental Health or the Australian Government

and in other cases they inform local service providers. In each case we try to draw out the lessons for national and international readers through appropriate publication.

In each case we have relied on the willingness of GPs and their staff to provide information and to support the research process. If participating in research interests could you please contact Dr David Perkins on 4226 7052. You never know, you might become a famous GP researcher. ■



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Norman's special interest is in gastrointestinal pathology, and he has over 30 research publications in the field. He has also contributed to textbooks of gastrointestinal pathology and co-authored a pathology text for medical students.



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Florence loses the lamp..... and gets a **laptop**

Over the last ten years, general practice has faced significant changes. Practice nurses and an increasing number of practice clerical staff have challenged GPs who have traditionally worked in small practices with skeleton staff. Anne Harding highlights the view from both sides of the fence.

Florence Nightingale has well and truly caught up to the 21st century, and you won't find her (or him) clutching a lantern caring for the sick in the streets of Wollongong, no, you'll find Flo working in a General Practice, armed with a computer creating disease registers, coordinating recall and reminder systems, care planning and conducting health promotion activities.

With the introduction of federal government initiatives including Practice Nurse Medicare item numbers and the Practice Nurses Incentive Payment, now available throughout the Illawarra to support practices employ a nurse, we are seeing more practices include nurses as part of their practice team to decrease GP workload and increase the practice's financial return. How they do this is the million dollar question, and we don't have to look far to find good examples in local practices to learn from. But it didn't happen overnight and it certainly didn't happen without communication and collaboration (and anxiety) amongst all practice team members.

I often see highly experienced nurses leaving the public hospital system to escape the cycle of not being able to provide the standard of care they are capable of delivering due to unrealistic staffing demands. They move into the general practice environment to find that it isolates them, also lowers their work satisfaction and denies them the opportunity to truly be a part of a team approach to providing quality care.

Many practices take an ad hoc approach to recruitment and induction of nurses, for whom general practice is sometimes a foreign environment. However, practices such as Thirroul Medical Centre and Lakeside Medical Centre adopted a structured

approach to nurse recruitment and induction, equipped with resources made available through IDGP. Both practices also allowed time for the nurse to adjust to the general practice setting by supporting them to undertake professional development and to set up information management systems which let them develop an understanding of the unique practice population they would be involved in caring for.

Employing a nurse purely for the purpose of providing clinical support is not going to result in a viable financial arrangement, nor is it sustainable to employ a nurse purely for the purpose of making money. Practices which have actually decreased GP workload and increased financial return have balanced their nursing staff workload across EPC, CDM, PIP/SIP activities. They have not adopted an ad hoc or 'cashcow' approach, but have proceeded in a planned and systematic manner, with the nurse regarded as a valued and respected member of an integrated primary health team.

While general practice has a lot to learn about working with the nursing profession, so do nurses. I often see nurses enter the general practice environment with the mentality that it is a 'soft option' career wise, or a step towards retirement. They get a rude shock when confronted with the demanding and diverse nature of general practice, and soon realise just how much at the frontline of the health system (or battle!) they really are, and head down tail between their legs they beat a hasty retreat. General practice needs nurses who are team players, committed to ongoing professional development and who see their role as an exciting career opportunity. In return, nurses working in general practice need GPs to value what they have to offer professionally, be included as a practice team member in the truest sense, and feel supported to meet the challenge of helping GPs care for an ageing population heavily burdened with chronic disease. After all, Florence lost her lamp long ago. ■

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The **GSM** as a precursor of *change*

Jeff Hall is a GP Director of the Illawarra Division and opening right arm fast bowler for the Division's cricket team. As such he brings a mature perspective on the changes facing GPs and practice staff involved in the GSM in his Bulli practice shared with Julie Blaze.

The prospect of the Wollongong Graduate School of Medicine starting next year is exciting for us at our practice at Bulli. My associate Dr Julie Blaze and I have elected to be involved and take students in the first session and hope that it will be useful for the new students and for us as practitioners.

As a small to medium sized practice it is important for us to plan medical staffing to meet our patient expectations and our obligations to the medical school. We have a small medical team who all work part time so dedicating time for the students to have quality teaching will involve some juggling. The amount of time dedicated each month doesn't seem too onerous to begin with but if we remain involved with the GSM it will increase.

Our practice has had medical students from the University of New South Wales and they have generally added to the fun and youthful feel to the practice.

I think the administrative and nursing staff will probably get more involved with the teaching of the Wollongong University medical students because the same students will be coming to the practice each month and will build up a stronger rapport.

Planning for room space to teach in will also have to be incorporated into the clinical sessions at the practice. We have all our rooms full during certain sessions so we might have to change our roster if the students are to have their own consulting space. Like most practices we have found out after our renovations that too many rooms are barely enough.

Personally I think the GSM is a great opportunity for Wollongong, our local health systems and my own career as a

General Practitioner. I am enjoying clinical practice and the challenge of running a small business. I also find General Practice as fairly isolating even within a small team who generally get on harmoniously. I sometimes miss the hospital dynamic of having a range of people around. I think having the additional stimulation of teaching and being involved with an institution like the University is exciting. I am not really interested in going research at this stage but I think it is great that

Personally I think the GSM is a great opportunity for Wollongong, our local health systems and my own career as a General Practitioner.

we might have a broader range of career opportunities to pursue as practitioners because we are involved with a teaching institution.

I still have some concerns about the ability of our small practice to dedicate resources to teaching students versus providing clinical services to patients. Many patients already complain that they can't get appointments to see us and I don't want to spend any more time away from my family. Also I don't feel that the PIP income for taking medical students is adequate remuneration particularly as costs in our practice will continue for the sessions we have students. I would like to think that the University would also contribute to our income because we will be the teachers of the course for which they collect fees to provide. Overall I am very positive about the prospect of the GSM and think this can be a fantastic opportunity for Illawarra General Practitioners and look forward to getting involved next year. >>>

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The teaching patient role

Susan Graham is the consumer voice on the Division's Medical School Expert Committee. As such, she has been party to the discussions that have partly shaped the form and direction of the general practice component of the School. In this article she discusses the contribution of the teaching patient.

A key emphasis of the GSM program is on community based training. The innovative and proactive program of the GSM aims, in part, to better prepare medical professionals for lives as Generalists and therefore has implications for local communities.

Patients have for some time been keen to assist in the training of doctors by allowing observation, but this role is to become more participatory with the extensive experiences planned at the general practice level. Essentially, there will be two main outcomes for the health consumer.

Consumers want comprehensively trained and compassionate individuals to assist in the management of their health issues. The GSM program promotes this by developing in medical trainees greater first hand experience of the complex and rewarding role of the GP in the lives of health consumers. Consumers will be in a position to assist by providing direct opportunity for trainees to practice specific clinical skills.

The implications of greater consumer involvement can be far reaching, in that it develops a level of joint responsibility toward effective training of health professionals and allows shared ownership of the outcomes of the program.

The potential exists to allow communities to form early vital bonds with those who will become partners in the management of our health, particularly where opportunities for supportive feedback are provided. This could be the most positive change which results from the new program.

With the recognition that effective services are an integral part of cohesive communities, especially in rural areas, consumers will welcome opportunities to work collaboratively in the development of future health care professionals. ■

Don't try emailing this one

The following Illawarra case from Karina Bronska focuses on what, to somebody, was regarded as an adverse effect.

A recent somewhat unusual case involved an 85 year old female with Alzheimer's Disease taking Aricept 5mg, Avapro 300mg, Tenormin 50mg and recently commenced Norvasc 5mg. Previous use of Aricept was noted with discontinuation due to adverse effects. The patient's husband reported a definite increase in his wife's sexual arousal since the commencement of Aricept. This effect was also evident with the first trial of Aricept 18 months ago and was the reason for discontinuation of therapy.

Both Reminyl and Aricept increase levels of acetylcholine, through similar mechanisms. Aricept inhibits the enzyme acetylcholinesterase, which breaks down acetylcholine, thus increasing acetylcholine in the brain. Reminyl (galantamine) is a cholinomimetic with a dual mechanism of action of acetylcholine on nicotinic receptors. It is interesting to note that the PI for Reminyl lists increased libido as an infrequent adverse effect (occurring in 1/100 to 1/1,000 patients), whereas Aricept lists it as a frequent adverse effect (occurring in at least 1/100 patients). Research into the control of human sexual activity found that it is modulated by a number of neurotransmitters. Libido is predominantly controlled by dopamine, whereas sexual excitement (erection in males and lubrication and swelling in females) is controlled by acetylcholine and nitric oxide. This is a possible explanation for the mechanism of Aricept and Reminyl increasing libido in some patients. As this appears to be a class effect, it is possible that it may occur with both drugs, although the incidence in the literature would suggest that it is less likely with Reminyl. Therefore, although there is no specific evidence to suggest that changing to Reminyl from Aricept may reverse the effects on libido, the reduced incidence may mean that it is more likely.

The patient's husband also reported a decrease in his wife's pulse rate since the commencement of Norvasc as he has been writing his wife's pulse rate down for a while. The product information for donepezil notes that increased cholinergic activity may have vagal effects on heart rate such as bradycardia. There have been 235 reports of adverse effects with donepezil to ADRAC until October 2004: bradycardia (14), bundle branch block (1), AV block (5), syncope (10), arrhythmia (2), MI/cardiac arrest (7).

Most patients recovered after the cholinesterase inhibitor was stopped or in some cases, reduced in dose. Many patients were hospitalised and in 4 cases a pacemaker was required. Four elderly patients died from suspected myocardial infarction. ADRAC advises that a pharmacodynamic interaction can be predicted with the concomitant use of beta-blockers or calcium channel blockers. ■

1 MIMS
2 Stahl S. The Psychopharmacology of Sex: Part 1: Neurotransmitters and the 3 phases of the Human Sexual Response. Journal of Clinical Psychiatry: 62:2; 2001.
3 Australian Adverse Drug Reactions Bulletin, Volume 23, Number 5 (October 2004): Cholinesterase inhibitors and cardiac arrhythmias

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one on one

with Julie Howe - Kiama/Gerringong

Demands of business complexity have meant that many practices have employed professional managers. In this interview for Biparietal, Julie Howe, Operations Manager for both the Kiama and Gerringong practices, discusses her bipolar management role.

Julie, what have been some of your roles over the years?

I am fairly new to General Practice, only 5 years. Being employed by both Kiama and Gerringong practices as their Operations Manager was my introduction to general practice. Previous to this job I worked in Human Resources with a superannuation company.

What are the staff profiles of each practice?

Kiama has 6 GPs, with 1 new GP coming in the next couple of months, 7 nurses and 7 administration staff. Gerringong has 7 GPs, 2 nurses and 5 administration staff. Although these may look like big numbers the majority of these people work on a part time basis.

Tell us how it works for you working for two different practices?

My role as the operations manager is to handle the financial and human resource management of the two teams. Each centre has its own team

leader who manages the day to day running of the surgeries so there are no real complications.

What are some of the benefits and challenges for the two practices in sharing your support?

Working across two sites, I have been able to share the human resources of both practices in emergencies. For example, if the nurses at Gerringong are both sick, I am able to borrow one from Kiama for the day to cover the Gerringong surgery.

Also, we have in the past been able to share the physical space in an emergency. On one particular occasion when there was a black out in the Gerringong surgery for a whole day, one of the GPs was able to work out of the Kiama surgery to see his patients. So as you can see having me working for both surgeries does have its benefits other than the obvious financial benefits of sharing the costs of my employment.

How has the introduction of government incentives changed the way that your practices do business?

It has enabled us to introduce nursing services at Gerringong and increase the nursing hours at Kiama. Nursing services have always been a priority at Kiama, even before the Government incentives were introduced. We have employed nurses at Kiama for 27 years. I guess the only other major change would be the use of care planning for the complex care patients.

What do you believe are the driving factors that have shaped the business model you work under?

My approach to my work has been to remain relatively low key. I let the practices manage themselves, but take away the burden of finance and HR which allows the GPs and nurses to do what they do best, patient care. I believe in striving for E.E.E.H. Efficiency, Effectiveness, Economy and Harmony. ■

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on the female *Nerd*

The Centre for Small Business and Regional Research and the School of Information Technology and Computer Science (University of Wollongong) piloted a study in the Illawarra examining how GPs are responding to the challenges of the technology revolution. The rather unexpected outcomes that follow are derived from two papers produced from the study whose principal author is A/Prof Rob McGregor.

The survey was developed to provide Australian regional general practices with an up-to-date perspective on benefits and drawbacks associated with Information and Communications Technology (ICT) adoption and to relate these, where applicable, to the day-to-day functioning of the practice. The survey was also seen as a mechanism to provide government and professional bodies with data that could be used to assist other practices with the adoption and use of the technology. Initially the study was piloted in the Illawarra, but this was extended to include four other Divisions of General Practice, Ballarat, Rockhampton, S.E.N.S.W., and the Hunter.

Amongst the outcomes was one interesting and unexpected finding that showed that female GPs gained greater benefit from ICT than male GPs. This was true

as to whether its use is for business or for clinical purposes.

The final finding recorded here is also something of a surprise. As distinct to other small or medium businesses, ICT in regional general practice does not appear to have reduced costs or workloads. More work no doubt needs to be done on this finding which seems to indicate that ICT has allowed

..... unexpected finding that showed that female GPs gained greater benefit from ICT than male GPs.

for upskilling practice staff, spending more time on patient care and improving communication with other GPs. The authors commented "It is difficult to believe that male GPs would not see these benefits as being intrinsically of value, and yet male GPs do not see that ICT has produced these benefits in their practices."

The study found strong evidence that the general practice benefits of IT were on the business side much more than on the clinical side of the practice. In fact, five of the six major benefits of ICT were related to business. A partial explanation for this may come from the "clear observation" that "skill with medical packages has a positive impact on the perception of some benefits derived from ICT adoption". In other words, GPs who aren't good at "IT" will gain least benefit from it and see least potential for its use. The obvious conclusion for the Division is that better IT training may improve both clinical care service delivery and business processes. Indeed, the authors cite other work that indicates that any exposure to ICT of any type is likely to increase the appreciation of the user for the potential for ICT in general. Interestingly, the study also found that when GPs adopt IT they do not discriminate

practices to do more rather than to do the same amount in less time.

The findings pose important questions to all Divisions of General Practice and, indeed, to GPs, particularly those of the male gender without an iPod. The study team thanks all GPs who have kindly taken the time to fill in the survey. We hope that the second survey, due later this year, will be supported by all GPs in the Illawarra. It is only through such instruments that meaningful data can be gathered and it only through this data that assistance and direction can be enhanced. ■



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Power *to the people*

Since 1999 over thirty local consumers from right across the Illawarra area have been involved in the Community Consultative Committee (CCC), established by IDGP. CCC Chair, Helen Gapps brings us insights into the increasingly sophisticated role of consumers.

Community members of the CCC bring a reality check to the planning work of the Division. They have seen a need for more community information in areas including childhood obesity, drugs, alcohol addiction, mental depression and managing medications.

The childhood obesity forum organised by the CCC complemented the important research being conducted by the University of Wollongong which was supported by local GPs. Researcher Dr Tony Okely makes the recommendation that parents consider making one day a week "technology-free" with no TV, video or computer games. Speaking at the Childhood Obesity Summit, Dr Kerryn Phelps echoed the feelings of our community in stating that to allow "kids to fall victim to obesity is negligence of the highest order...child abuse by any other name".

The Committee's (purely theoretical) interest in drugs and alcohol, has also matched the Division's involvement in Managing the Mix. This program helped fund

The Committee seeks advice from both health consumers and doctors as to how it can work effectively as a support group within the IDGP.

community activities such as family counselling through the Salvation Army and assisted the Southern Youth and Family Services to run the **Creating Conversations** program. This program attempts to bridge the gap between parents and their children when alcohol or drugs have poisoned their relationship.

The Committee continues its interest in Dads in Distress which it assisted to get underway. It has also attempted to work with the homeless community by introducing them to real GPs in order to demystify their perceptions of doctors. Jim Turner has been a stalwart in this.

The CCC is perhaps best known for running the Illawarra Family Doctor of the Year and Illawarra Practice of the Year Award. These awards provide an opportunity to publicise special patient care and exceptional general practice.

The CCC's strategic plan centres around eight main areas of health focus. These include young people's health, practice management and development, lifestyle, the new Graduate School of Medicine and improving the community interface. So the Committee is currently working on developing strategies for its own "hit list" of community health issues within these broader focus topics.

The "hit list" arises from issues communicated from the wider community. At present the list

includes such topics as the shortage of GPs, the distrust of GPs and the health needs marginalised people have, the difficulties for carers of dementia patients when the patients regularly deceive their doctor, disabled parking near surgeries, medication side effects, how to keep doctors effectively informed about the many support organisations which can help their patients, costs of and access to specialist treatments (so that many GP recommendations never happen), "prescription shopping" and health problems in specific housing estates.

CCC members also endeavour to speak to community groups about IDGP. The CCC has representation on the Steering Committee for the new Integrated Primary Health Care projects and also was involved recently in interview panels for the first intake of students for the Graduate School of Medicine. The School's progress is of particular interest to the Committee as it will involve direct community participation in its teaching programs.

The Committee seeks advice from health consumers and doctors as to how it can work effectively as a support group within the IDGP. Do you have an issue that you would like the CCC to address? Please contact Monique Piper on 4226 7052. ■

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Exercise Physiology:

Riding the cusp of a major trend in lifestyle interventions

Exercise physiologists (EPs) are university-trained exercise science professionals who have specialised in either health and fitness or exercise rehabilitation. The development of this specialised field of exercise science has only occurred in recent years. Illawarra was one of several Divisions that successfully lobbied for EP inclusion as an EPC item. In this article Linda Blackmore examines their changing role in primary care.

"We know of no single intervention with greater promise than physical exercise to reduce the risk of virtually all chronic diseases simultaneously" (Booth et al, Journal of Applied Physiology 2000). This fairly broad claim extolling the virtues of exercise is one of a few to be mentioned in this article that lie at the heart of the passion that EPs feel about their work.

EPs provide professional services in the area of exercise as a treatment strategy in physical rehabilitation, as a preventative strategy for disease prevention, and work hardening as part of establishing and sustaining functional independence. Clients include those with diabetes and pre-diabetes, cardiovascular disease, arthritis, osteoporosis, metabolic syndrome, obesity, hypertension, musculoskeletal injuries, depression, Down's syndrome and immunological disorders.

EPs are trained to assess the patient's readiness for behavioural change and may spend much time preparing the patient to take the first important steps to change perception and behaviour.

EPs also assesses a patient's functional capabilities, undertake risk stratification for exercise modes and intensity and provide individual or group supervision.

As Baster and Baster-Brookes have recognised (AFP, Vol 34, (6):402-512, 2005), "while medical students spend years learning about how to prescribe drugs, they are rarely instructed on the value of the exercise prescription for various medical conditions, or how to prescribe it". In 2004, the Division recognised the medicolegal vulnerability of GPs prescribing exercise and joined forces with the Faculty of Health Science, to provide planned exercise interventions to diabetics through a program now known as GPEP. The University of Wollongong is one of a hand full of universities that offer courses in exercise physiology.

But diabetes is but one of many conditions that challenge our ageing community. Dennis Taafe from the University of Queensland has found that appropriate exercise, specifically resistance (weight) training, can arrest the age related decline in muscle mass and its associated "reduction in muscle

function, physical performance, quality of life, and loss of independence". (Taafe, AFP, Vol 35, No 3, March 2006).

An NHMRC grant, Aim Hi, has seen the Division working with the Illawarra Institute of Mental Health delivering exercise programs to patients with depression and anxiety. There is good evidence for this. The Medical Journal of Australia (3rd may 2004) published an article that reported a Western Australia trial of 61 patients with Chronic Fatigue. Quoting the author, the MJA recorded that "Improvements may be associated with patients abandoning avoidance behaviours. Scores for depression improved after exercise, along with attentional function, while mental fatigue decreased".

Whilst evaluation, motivation and risk stratification are important, sustainability is also critical. Results from our follow-up survey of participants from the GPEP program suggests a high proportion of participants are maintaining exercise habits after the program finishes. While 47 participants from 2004 and semesters 1 and 2, 2005 responded to the survey, 49% were still doing their exercise regimen...and an additional 21% were still exercising although doing other types of exercise.

In conclusion, planned and patient specific exercise is rapidly becoming part of the treatment regime for the chronically ill. EPs can be a valuable resource to the local GP. Most EPs work in private practice and waiting lists tend to be short. The Australian Association for Exercise and Sports Science (AAESS), the professional organisation responsible for EP accreditation, sets strict guidelines for membership and accreditation.

A list of Illawarra EPs can be found on the AAESS website www.aaess.com.au or at the IDGP website under Programs/Diabetes/Diabetes Service Directory. ■

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