

bipolar

A painting of a beach scene. In the foreground, a large, dark blue wave is breaking. Several people are swimming in the water, and one person is surfing on the wave. The background shows a bright, hazy sky and a sandy beach. The overall style is impressionistic with visible brushstrokes.

Quarterly Communicator of the Illawarra Division of General Practice Autumn 2008

a local perspective of general practice

Quarterly Communicator



An informative Resource for Medical Professionals

Illawarra Division of General Practice

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front cover

The front cover image is an oil on canvas titled "On the High Tide" by local artist Dr Jenny Asquith.

Jenny's art will be on display at an exhibition from 13th- 25th May 2008 at Bondi Beach Pavilion. The exhibition is open daily 10am-5pm.



Thanks to our 'Partners in Health',
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Bipolar, Autumn 2008

**Each quarter I write an introduction to the articles and their authors.
Not so this time.**

This time I am using this opportunity to acknowledge the extraordinary support and concern shown by a special group of colleagues at a time of personal sadness.

In losing our daughter Megan, Robyn and I have walked a different journey to one we would have chosen, but not one without its beauty nor its riches.

As GPs, each of us is exposed to the full spectrum of human existence and grief is part of that vicarious experience. And we always hope that it is vicarious but the fear of experiencing some of what our patients experience is omnipresent.

The support that Robyn and I have experienced from our medical colleagues is, I think, a measure of that vulnerability we all feel. For we know that time may not necessarily heal; that some wounds may not altogether close.

I was surprised to find how important it was for me that in that vast sea of faces at the funeral were so many that I had known as part of medical practice.

I hadn't realised the importance of just being there.

I hadn't realised the significance of cards and of flowers.

I hadn't understood the distress of Megan's GP in her own experience of loss; the traumatic severance of the doctor/patient continuum.

My own GP who made the promise that we would never meet without mentioning Megan.

I hadn't realised how important GPs were in organising support for siblings left shocked and stressed. How none of my daughters' own peer groups had ever had to confront that kind of grief.

The vast silence that sits around losses like this.

So thank you for your humanity.

Its been one of life's riches.

Andrew Dalley

Your Time

The Illawarra GP Health and Lifestyle Program

Its 6.45pm and you're in the middle of your last consult (an early night really).

Last on the list for today is Bob, a 55 year old male who has been developing a rather large 'spare tyre' over the past six months he has been frequenting your practice.

The topic of exercise is raised — and quickly unraised.

Bob just can't motivate himself to do it.

You've got to admit you kind of know how he feels.

Living a healthy lifestyle and working in general practice sometimes just doesn't add up. Doing long hours in what can be a sedentary and stressful environment is not particularly conducive to eating well and being active.

But here's the thing- your body needs it just as much as Bob's does. This is where the Illawarra GP Health and Lifestyle Program comes in.

A specialist health and lifestyle program is

now being offered to all GPs in the Illawarra Division.

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Daryl Sadgrove

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Annual Survey of Members

Part 2

As part of the 2007 survey of members, member satisfaction with our communication, practice support, services and GP hospital/integration were examined.

Overall, the majority of respondents seemed satisfied with our communication.

78% of respondents satisfied with the division's role in representing the interests of local GPs and 75% satisfied with the promotion of general practice in the local media.

59% were satisfied with this publication (quarterly communicator) and 27% were unsure, perhaps the ever-changing name of bi (generic) creating some confusion.

As the Division looks more towards a practice support role it was interesting to see that approximately 50% of respondents were satisfied with the assistance provided in practice management and nursing, only 3% were not satisfied however the remainder were unsure. This indicates either that further work is required to provide support in these critical areas or

that support is being provided to practice staff rather than to GPs.

Overall respondents were satisfied with the provision of information on immunisation (75%) and education in quality prescribing (78%).

50% of respondents were satisfied with the problems rectified by the IT service (OTIIS) and the timely manner in which they were done. However 10% of respondents were not satisfied with this service.

This suggests that our staffing of four technicians may still be inadequate and that customer satisfaction requires closer attention. Interestingly 25% were unsure and may be yet to use our expanding service.

As we turn to GP satisfaction with the hospital we found that only 31% of respondents were satisfied with the

appropriateness and timeliness of patient information included in discharge notifications.

Respondents were also dissatisfied with the quality of information from the area hospital about surgical patients (30%) and medical patients (39%).


There was also some dissatisfaction (32%) with the quality of information from the emergency department.

Respondents were however very satisfied with the arrangement for sharing clinical care between general practice and hospital for obstetric patients, a noteworthy achievement of the Antenatal Shared Care Program managed so competently by Christine Comber.

Dr Kellie Marshall
Deputy Chief Executive Officer

Survey

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From the Pharmacopeia

Has the 21st Century seen the demise of the 10mg Vitamin K tablet? Margaret Jordan discusses the potential for GPs to prescribe Vitamin K in ampoules as an alternative oral preparation.

According to recent anecdotes, the management of over-anticoagulation for residents of aged care facilities is not in accordance to consensus guidelines. (Baker, Coughlan et al. 2004).

Historically, over-anticoagulation has been managed with oral 10mg vitamin K tablets (Konakion®), however this is associated with the risk of thrombo-embolism and also difficulty in re-anticoagulation.

Resistance to warfarin can continue for one week or more when high-dose (10mg or greater) is administered. Cases reported in the literature have described thrombosis recurring after high doses, as well as sub-therapeutic INRs sustained up to four weeks after the administration of high oral doses. (Fugate, Nichols et al. 2004)

Australasian recommendations

The most recent recommendations from the Australasian Warfarin Reversal Consensus Group is for the management of overanticoagulation to be individualised

depending on both the risk of bleeding and the INR result, with doses of vitamin K above 5mg only considered necessary when there is clinically significant bleeding attributed to warfarin. See table below, adapted and reproduced with permission. (Baker, Coughlan et al. 2004).

How can you get 1mg oral vitamin K?

As a result of the scare, erroneously associating IM vitamin K and childhood cancers, Konakion MM Paediatric was formulated for IM, SC and ORAL administration.

Although the packaging is of sterile formulation of ampoules, there is a dropper supplied with each package to enable oral dosing.

This allows for a more accurate dosing of 0.2ml (2mg) for a person with an INR of, say five, and a high risk of bleeding.

What about nursing homes?

INR fluctuations are quite common in nursing homes for various reasons including the altered pharmacodynamics of the

continued page 10



Guidelines for the management of an elevated international normalised ratio (INR) in adult patients without bleeding

Clinical Setting INR higher than the therapeutic range but < 5.0; bleeding absent

Action Lower the dose or omit the next dose of warfarin. Resume therapy at a lower dose when the INR approaches therapeutic range. If the INR is only minimally above therapeutic range (up to 10%), dose reduction may not be necessary.

Clinical Setting INR 5.0-9.0;* bleeding absent

Action Cease warfarin therapy; consider reasons for elevated INR and patient-specific factors. If bleeding risk is high, give vitamin K₁ (1.0-2.0 mg orally or 0.5-1.0mg intravenously). Measure INR within 24 hours, * resume warfarin at a reduced dose once INR is in therapeutic range.

Clinical Setting INR > 9.0; bleeding absent

Action Where there is a low risk of bleeding, cease warfarin therapy, give 2.5-5.0mg vitamin K₁ orally or 1.0mg intravenously. Measure INR in 6-12 hours, resume warfarin at a reduced dose once INR < 5.0. Where there is a high risk of bleeding, * cease warfarin therapy, give 1.0 mg vitamin K₁ intravenously. Consider Prothrombinex-HT (25-50IU/kg) and fresh frozen plasma (150-300mL) measure INR in 6-12 hours, resume warfarin therapy at a reduced dose once INR < 5.0.

*Bleeding risk increases exponentially from INR 5 to 9. INR > 6 should be monitored closely. * Vitamin K₁ effect on INR can be expected within 6-12 hours. * Examples of patients in whom the bleeding risk would be expected to be high include those with active gastrointestinal disorders (such as peptic ulcer or inflammatory bowel disease), those receiving concomitant antiplatelet therapy, those who underwent a major surgical procedure within the preceding two weeks, and those with a low platelet count.

What Goes Down

In *What Goes Down*, HMR wonder pharmacist Karina Bronska presents some case studies of live (but only just) Illawarra patients.

Recent reports have estimated that 25% of patients who seek medical attention for a serious medical problem are also using complementary therapies, and 70% of those patients do not disclose those practices to their physician.

During a recent HMR, an 87 year old man with pronounced renal impairment and under the care of a renal physician was discovered to be taking over 20 different complementary therapies from a mail order company all on a prn basis.

These preparations included vitamin A, vitamin B complex, vitamin C, cod liver oil, vitamin E, ginkgo biloba, selenium, magnesium, zinc, three different multivitamin preparations, coenzyme q10, Macu Vision, valerian, starflower oil, grape seed extract, a digestion supplement and a hair and nails supplement (the whole collection can be seen in the image).

A green shopping bag full of these was removed during the HMR interview.

Another recent example is that of a 60 year old male who takes all his supplements regularly, mostly for the indication of "good health".

None of the following were listed in the current medications provided with the GPs referral, and when asked if the patient had informed the GP about these, the patient indicated that this was not necessary as they were not medicines.

Vitamin E, ginkgo biloba, St John's wort, valerian, a multivitamin, Macu-Vision, Lutein Vision, vitamin C, fish oil, evening primrose oil and coenzyme Q 10 were all taken daily.



This patient also takes low dose aspirin and several interactions could have occurred with fish oil, vitamin E, ginkgo biloba and evening primrose oil as all of these may increase the risk of bleeding when combined with low dose aspirin.

Warfarin is a magnet for drug interactions and a local 74 year old lady was found to be taking

six tablets of Fat Blaster daily along with her regular warfarin therapy.

Fat Blaster is a well advertised diet pill and contains brindleberry, guarana (equiv. caffeine 22.5mg), bitter orange, gymnema, ginger, coleus, green tea, kelp, psyllium husk and chromium picolinate.

In this situation there is likelihood of warfarin antagonism by vitamin K in green tea as well as additive anti-platelet effects due to the ginger.


However, the total amount of daily caffeine from the Fat Blaster amounting to 135mg should not be overlooked.

Herbal products and dietary supplements are widely available in supermarkets and other retail outlets, as well as by mail order.

It is important for all health professionals to be informed about available products and to be aware of any potential problems associated with their use.

HMR can help to unearth any thus far hidden potions.

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Workload Stress, Mental Health and Help Seeking in GPs



In this article, Prof Frank Deane, from the Illawarra Institute for Mental Health, presents a convincing argument for improving our own help seeking behaviours.

The recent IDGP 2007 Annual Survey found that although less than 10% of GPs reported dissatisfaction with their work, “only 19% of respondents indicated that they were coping well with their current workload” (p. 5).

The good news interpretation of this is that despite workload struggles, GPs are still mostly satisfied with their work. However, another view might be that there is considerable long term risk associated with unsustainable workloads that appears to be getting worse.

The highest source of work pressure amongst the 136 respondents to the 2000 IDGP Annual Survey were workload issues such as, too many different things to do, working long hours and insufficient time to complete tasks satisfactorily.

So, workload pressure has been a long term issue for Illawarra GPs. The risk of persistent workload pressure is stress and burnout.

Stress and job satisfaction are highly and inversely correlated (Linn et al., 1985; Sutherland & Cooper, 1993), so if unsustainable workloads are maintained then it seems likely that loss of job satisfaction will eventually follow. More worrying are the potentially adverse health effects of sustained stress.

The main mental health problems experienced by doctors are depression and alcoholism (Firth-Cozens, 2001). Of course, these multiple issues are interlinked. Both conceptual models and research with physicians suggest perceived stress leads to low job satisfaction and poorer mental health (Williams et al., 2001). In turn, lower job satisfaction and poor mental health are related to greater intentions by physicians to leave direct patient care (Williams et al., 2001). More specifically, high job strain has been associated with depression (D’Souza et al., 2005) and depression is more common amongst those who drink alcohol (Frank & Dingle, 1999).

Alcohol problems worsen with age amongst doctors (Flaherty & Richman, 1993). Firth-Cozens followed over 300 4th year medical students some 11 years after the initial assessment and found that amongst these now senior doctors 65% reported using alcohol as a coping strategy. In the 2000 IDGP Annual Survey 25% described themselves as regularly drinking alcohol with 8% wanting to drink less. Unfortunately, GPs are reluctant to seek help for mental health problems.

An Australian survey of 231 GPs and their health help-seeking behaviour found that 90% were “reluctant to consult for psychiatric problems” (Davidson & Schattner, 2003).

In the 2000 Annual IDGP survey GPs were asked to rate how likely it was that they would seek help for “drug and alcohol problems” and “persistent suicidal thoughts” from a list of different help sources (e.g., Psychiatrists, GP, friend). For drug and alcohol problems GPs were most likely to seek help from another GP, the NSW Doctors’ Health Advisory Service, family, or friends.

For persistent suicidal thoughts they were most likely to seek help from a psychiatrist, GP or family. However, as levels of depression increased, intentions to seek help from GPs and family decreased (Davies, Deane & Dalley, 2006).

Almost 12 percent of GPs indicated they were likely to not seek help from anyone for drug and alcohol problems and 10% indicated they would not seek help from anyone for persistent suicidal thoughts.

There appears to be a wide range of reasons for GPs’ reluctance to seek help for mental health problems. These were summarised in a review by the NSW Doctors’ Mental Health Implementation Committee (1999) and included — difficulties changing role from provider to patient, shame, loss of credibility,

loss of control, and negative attitudes toward psychiatry.

The review also suggested that “Doctors with a mental disorder have a tendency to deny, minimise and rationalise their own symptoms and behaviours” (p. 4).

These findings have a number of implications.

Firstly, preventative interventions and support to help GPs manage workload stress are essential. These may range from practice management support, through to seminars on stress management (e.g., Winefield, Farmer & Denson, 1998).

There is a need to help GPs identify when they are experiencing mental health symptoms. Greater self awareness and tools for self monitoring should be provided and encouraged (e.g., symptom measures, irritability, sleep, alcohol monitoring). Each GP should have their own doctor. There should be programs to address attitudinal and stigma related barriers to seeking help.

Given that other GPs and family were cited as likely sources of help, there is a need to consider strengthening these sources of support.

There appears to be an increasing move toward group practices and GP colleagues need to be sensitive to signs and symptoms

of depression or other mental health problems in their work mates. Seminars for group practices and agreed protocols for handling concerns about fellow GPs well-being should be developed in advance.

There is a need to support family members of GPs and, in particular, spouses. Anecdotal reports suggest that some doctors who are psychiatrically ill present for treatment as a “marital problem” (Myers, 1992).

It is thought that for some people seeking help for marital problems may reduce some of the stigma and shame that might accompany an admission of psychiatric impairment.

Family members of GPs are also likely to experience concerns about stigma that could be addressed during workshops. A qualitative study of stress amongst GPs and their spouses indicated that dissatisfaction with detachment from family, concern regarding workload, communication problems and interruptions were universally expressed by GPs’ spouses (Rout, 1996).

Finally, there is a need to sensitise GPs to the surreptitious phenomenon where higher levels of depressive symptoms are associated with lower levels of help seeking intentions. This process appears to often occur below an individual’s level of awareness, in part, because it starts before levels of depression reach clinical

significance. What research appears to be showing is that even low levels of depression can have a subtle influence on our willingness to seek help from others.


The mechanism by which this happens is not yet clear. It may be a function of a general social withdrawal or mediated by the negative thinking that accompanies a depressed mood. Still, it highlights the need for GPs to seek out the natural informal supports (e.g., friend, family, colleagues) in their environment at the earliest possible time.

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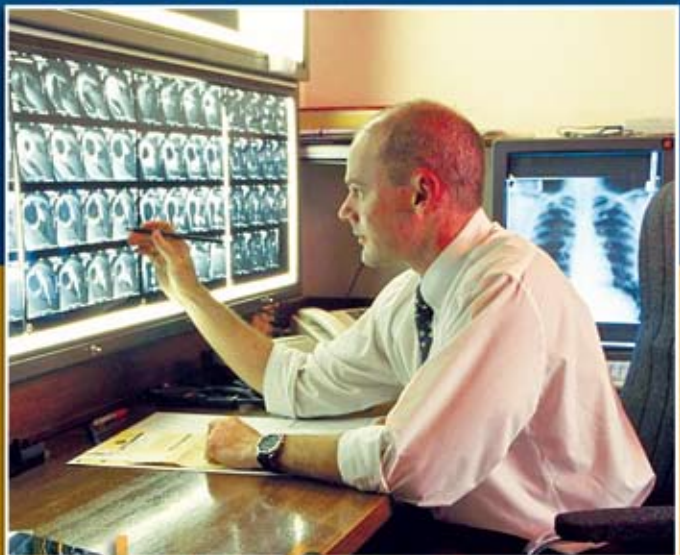
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From the Pharmacopeia

elderly, communication difficulties regarding altered doses of warfarin, and changes to other medications and diet.

The oral dose of vitamin K offers a route and dosing that is optimally suited to nursing homes, as the oral tablets then do not have to be used with the inherent risks as stated above, the resident does not necessarily have to leave the facility, nor is a visit from a GP necessary.

As vitamin K is Schedule 3, a box of ampoules can be purchased by the GP for general patient use, or by the facility and kept on site.

Where do you get it?

For less than \$10, a box of five ampoules can be purchased from DVM medical supplies at Unanderra. Please contact Margaret Jordan or Glenda O'Halloran at the IDGP for further information. A Warfarin Reversal Chart is also available on request.

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Reflections



In *Reflections*, Dr Ramnik Shah retraces the path of an Indian out of Africa to a new home and a new type of medicine. In retirement, Ramnik's story may sound very strange and foreign to today's GP Registrars learning to do their first Team Care Arrangements.

I was born in Zanzibar, a tiny island on the East African Coast in the Indian Ocean whose economy was dependant on producing ninety per cent of the world's production of cloves. I completed my schooling in Zanzibar and was admitted to the medical school, Makerere University, Kampala, on a Zanzibar government scholarship, qualifying in 1962.

An early mentor was Dr Dennis Burkitt (of Burkitt Lymphoma fame). I did general surgery and lymphoma work under him. There were many Australian influences at this early stage of my medical career.

I worked under Dr Ronald Huckstep doing orthopaedic surgery and correcting contracture deformities of poliomyelitis; later, he was appointed as the Professor of Orthopaedic Surgery at NSW University. I undertook general surgery under Dr Joe Shepperd who was later appointed as the Professor of Surgery at Tasmania University.

I went to the United Kingdom in 1967 on a Uganda Government Scholarship for further Post Graduate surgical training and obtained the fellowship of the Royal College of Edinburgh.

I returned to Uganda in 1969 and worked in the Department of Surgery at a teaching hospital in Kampala. Again, I did a lot of surgery and a bit of cardiothoracic surgery under Professor Rowan Nicks from RPAH Sydney; Professor Nicks would visit Kampala from time to time as a voluntary surgeon teaching us cardiothoracic surgery. Later I went to country hospitals as a surgeon — this was quite an experience as you are on your own doing all sorts of surgery imaginable, including general,

orthopaedic, gynaecological, caesareans, forceps delivery and tubal ectopic pregnancies (which were quite prevalent in Uganda).

A change of political events occurred in Uganda when Idi Amin came to power. All the people of Indian origin were forced to leave the country at short notice and my Uganda passport was confiscated so I became a stateless person. With the help of the Australian High Commissioner we left Uganda safely but penniless, so with a wife and two little children four and three years old, I arrived in Sydney in 1972.

We began our lives in migrant hostels initially in Coogee and then Villawood. Thanks to the recommendation of Professor Huckstep I was able to get a job at Parramatta District Hospital. In those days PDH used to be the busiest in the Sydney area.

I did a lot of general, plastic, urology and vascular surgery under famous surgeons from RPAH. Despite a wealth of surgical experience in Uganda and PDH there was no time to waste in pursuing a surgical career.

Further surgical training with a young family and no financial support was difficult, so I decided to start a general practice with a surgical specialist practice (in those days one could do both) on the 30th June 1974 in a small and beautiful place called Figtree.

I worked over the years in many of the area's hospitals; such as Bulli District Hospital, St Anthony, Market Street, Shellharbour Private and Illawarra (now Figtree) Hospitals.

Eventually I had to give up surgical work because of rising insurance costs, sub-specialisation of surgery, newer laproscopic techniques. I was not getting any younger and my general work practice became heavier. I concentrated in general practice, doing lots of minor surgery, house calls and nursing home visits.

General Practice was and still is very satisfying work. I have enjoyed it thoroughly and found it very rewarding. I have made many friends and have fond memories which I will treasure for the rest of my life.

I have looked after my patients to the best of my ability and I thank them for letting me be a small part of their lives. The sad thing about retiring is that I could not find a replacement to take over my practice.

A solo general practice is not everyone's cup of tea these days, there were mixed feelings amongst the patients, most people were happy for me and wished me all the best in a well deserved retirement after forty-six years of medical practice.

Some have been sad and they have not been able to find a GP in the area, some were in tears and will definitely miss me and I will miss them too.

So a big heartfelt thank you all, but not a goodbye to Figtree, Wollongong and Illawarra from a stateless refugee from Uganda who has done very well and has enjoyed his work, his patients and his family.

Taking Care of Business

Starting a new job can be a tough time, and joining a busy practice is no exception: new colleagues, a new culture, new systems and new information to absorb. *Taking care of business* this quarter discusses strategies to ease a new staff member effectively and safely into the practice environment.

An effective way to ease some of the pressure during this stressful time — on the new employee and on the staff whose role it is to welcome and train them - is to take a structured, comprehensive and documented approach to the induction of the new employee.

A well planned and effectively implemented induction will provide many benefits to all involved by ensuring the new employee:

- ◇ is made to feel welcome and reassured their learning and integration into the team is a priority for their new employer
- ◇ becomes confident and productive more rapidly than with an ad hoc approach to their commencement
- ◇ develops an understanding of how to work safely in their new environment
- ◇ is more likely to settle into the team in the longer term, resulting in a more stable workforce and reducing the cost and disruption associated with employee turnover

There are also regulatory imperatives that make an induction program advisable. The Occupational Health and Safety Act 2000 specifies that employers must provide “information, instruction, training and supervision necessary to ensure the health and safety of employees”.

A documented induction program and staff records to demonstrate its implementation, is a good starting point in providing evidence of compliance with OHS responsibilities.

Additionally, the RACGP Standards for General Practice include the requirement that practices have an induction program ‘for new GPs and staff’ (criteria 4.1.1e)*.

This indicator is assessed through ‘document review’, so again a documented program and evidence of its implementation are advisable.

There is no one size fits all approach to induction but generally an effective program will involve:

- ◇ Introduction to new colleagues
- ◇ Tour of the new workplace and facilities
- ◇ Clarification of any issues surrounding contract and personnel administration
- ◇ Overview of organisation structure, philosophy, services, culture
- ◇ Introduction to organisational policies and systems including code of conduct, occupational health and safety, emergency and evacuation, human resources, IT and privacy policies
- ◇ Introduction to operational procedures and protocols
- ◇ Clarification of role, responsibilities, expectations and priorities

A couple of excellent sample induction checklists for general practice are available - AGPAL members can access one at www.qip.com.au, and the Australian General Practice Network has induction resources at www.agpn.com.au/nigprecrut/.

When developing your own induction program, you might like to use your checklist to develop a timetable of activities and meetings over the new employee’s first couple of days or, if appropriate, first couple of weeks.

Identify on the timetable who will be running each session, provide room for the new employee to acknowledge they

have attended the session and to sign off at the end that they have completed their induction.

Where possible, involve more than just one or two staff in the induction process. Benefit from existing staff members’ areas of expertise by sharing the load as well as encouraging the development of new working relationships right from the beginning.

In particular, ensure the new employee’s line manager plays a key role in clarifying the role and responsibilities and in monitoring how the new employee is settling into their new environment.

You might like to consider identifying a mentor to provide informal support and assistance over the first month or so.

Touch base with the new employee on a regular basis, and particularly at the end of their induction, to ensure they are confident with their progress and to identify if there are any gaps in their knowledge.

And lastly, get feedback from ‘inducted’ employees and their supervisors on how effective the process has been and use this information to continually improve your ability to develop a productive, confident and well informed team.

*Practices that have not employed new staff in the past 3 years are not required to have an induction program already developed but must be able to explain what they plan to do when employing a new staff member.

Nicola Bunt

Underbelly of Frailty

Each quarter in *Underbelly of Frailty*, a GP member is coerced into revealing something of themselves to their colleagues. This quarter, Gerringong GP and IDGP Director, Russell Pearson, takes a measured look at doctors, desire, delusion and dementia



Some years ago I was invited to address an audience of six and seven year olds at the local primary school.

They were doing a project about various occupations of people in their community.

As I mused about how to distill the essence of being a good GP into a brief simple address, I decided that kindness was both an essential ingredient of being a good GP and something that every child understood.

My partners then had input. Robyn Dalley said that good communication skills was half the battle in general practice.

Certainly being a good listener is the first step.

My patients do not always benefit from attending too closely to my advice!

As I discussed my speech with John McAlpine over morning tea he reminded me of the importance of being able to keep a straight face.

Certainly on reflection I recall getting myself into trouble by smiling, when my patients had believed their present predicament was no laughing matter!

The children seemed to enjoy my talk, although not as much as their teachers. The brighter students dutifully wrote down the three essential characteristics of being a good GP for their project.

They enjoyed exploring the contents of my doctor's bag, and elementary auscultation. They exuded such innocent charm that I left them with some important parting advice and we practised the art of surreptitiously standing on one leg. "Always stand on one

leg in lifts" I explained — "if it plummets to the ground you will emerge with only one broken heel!"

However, despite my obvious talent for engaging the minds of young people, for reasons I cannot explain, I have developed a largely geriatric practice.

At work, I have always felt I cut a dashing figure, keeping trim, or relatively so, dressing smartly (at least at the beginning of the week) and, if greying a little, at least not balding.

So I have not been surprised when the occasional older patient would flirt with me and comment favourably on my appearance as I traversed the waiting room.

Sadly, however, that patient would invariably develop unmistakable signs of dementia. Hence, Pearson's sign of early dementia. My partners and colleagues are convinced of its reliability.

My receptionists reach for the mini mental sheet when they observe it. Succumbing to the urge to flirt with Dr Pearson, sadly, is a poor prognostic sign.

At least I have made my mark in the profession, even if I have been forced to revise my opinion of my own elegance.

But I'll let you be the judge. Observe the accompanying photograph. It was taken at last year's staff Christmas party, at that stage of the proceedings when the belly dancing had commenced. Would you flirt with this man?

Dr Andrew MacKenzie-Wood

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Electrons Behaving Badly

OTIIS boffin, Troy Smith, again takes on the power of the electron as it sets about to niggle, nudge or negate your IT system.

We need surge/spike protectors for our systems to keep our electrical equipment safe from excess voltage. Unfortunately the power running to your electrical equipment is not always “clean” and at a constant level.

Small fluctuations in power can cause small hiccoughs in the daily grind (e.g. random reboots, file corruptions and odd lockups and freezes).

Large fluctuations can cause the computer to completely “fry”. In worse cases, the whole system can be rendered useless from a large surge.

Most people think that power fluctuations come from storms and storm damage — this is true but problems can also come from other electrical devices such as fridges, autoclaves, washing machines and air conditioners, even hairdryers and vacuum cleaners can cause problems.

These devices may not cause the same amount of damage as lightning or a storm but they can slowly eat away at your equipment causing it to eventually fail.

There is a simple, cost effective solution — a surge protector/spike arrestor!

These protectors work by channelling the extra voltage into the outlet's grounding wire, preventing it from flowing through other electronic devices while at the same time allowing the normal voltage to continue along its path.

They come in different shapes, sizes and costs. There are \$10 solutions available in discount stores and shopping centres.

While not providing a perfect solution they are better than nothing, stopping some surges and spikes but they do not have the lifespan and build quality of the better brands.

For instance, the better brands have a light to indicate when they have been rendered ineffective, offer a quick response time (measured in nanoseconds!) and some manufacturers offer to replace the surge protector if it suffers from a power surge. Commonly these better brands also have the capability to

filter the telephone line as this is also a common problem area as a telephone line commonly carries a small electrical current. The best solution for most practices is to install an uninterruptible power supply (UPS).

These devices have a battery backup along with surge protection so your electrical equipment is safe from power fluctuations while having the added bonus of being able to work for a limited timeframe on backup battery power (depending on the model and the amount and types of equipment connected to it).

UPS costs vary dramatically starting from as little as \$90 for an entry level UPS ranging up to over \$350 for protection for your server equipment.

OTIIS staff will happily advise you on the best power protection for your needs, whether it be a simple 4 port power board up to a large UPS for your office server. For more information tel 02 42267056 or email otiis@idgp.org.au.

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