



**idgp**

Summer 2009



**BIOSESTON**



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## front cover

The front cover shows Dr Seng Ooi, Dr Rashmi Murthy, Mrs Usha Fernandez and Dr Cedric Fernandez of Dapto Medical and Family Practice being presented with the Illawarra Practice of Year award 2008.

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# Bioseston, Summer 2008-2009

**Bioseston is the living component of water including plankton and various bacteria. It represents our theme of "Workforce" this quarter in that it reminds us of the broader environment which impacts, and at time overwhelms, our GP workforce.**

In the Illawarra we are living in a region which is literally bounded by areas that have incentives to attract GPs away from our community.

Incentives to the north are available under the Outer Metropolitan initiative, to the south and west are incentives available to rural practices but not to "Other Metropolitan", as the Illawarra region has been determined.

An unsympathetic State Government has turned down 26 applications for Area of Need status from Illawarra practices in 2008.

As a result, our GPs are busier than ever and that's saying a lot.

We've taken the issue of increased numbers of GP Registrars directly to the Federal Health Minister and we should see an increase locally.

In **Brokering what ain't brokered**, Lauren Hickson describes one of our clinical services designed to ease the workload of local GPs.

An article from the HCCC, is a healthy reminder that, in times of turmoil, the Bioseston bacteria population may be perceived as largely coliform.

Patient complaints are always disturbing and prevention and early intervention is simply good public health.

In **Taking care of business**, Nicola Bunt takes on the management of staff complaints at a time in which practices are getting larger and staff numbers are therefore increasing.

**Electrons behaving badly**, Troy Smith's last article for us, also reminds us of the coliforms that coexist in the bioseston, in this case in the form of Malware and, in

the case of epidemiologist Phillippa Binns' article, in the form of a pandemic.

The phytoplankton of them all, Dr Mark Condon, gives us a brief but pleasant relief in **Reflections**, whose stage he shares with his son and microplankton, Danny.

There are also our usual columns and, from all at the Division, our best wishes for a year that has already proved so challenging for us as a national community.

Andrew Dalley



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# What Goes Down

**In What Goes Down, Margaret Jordan answers questions posed by two of our GP Members. Preventing osteoporosis and further fractures has been the National Prescribing Service most recent topic in focus, delivered through the IDGP. Besides the ubiquitous issue of osteonecrosis of the jaw, there were other contentious matters generating healthy debate.**

GPs tend to pose obscure questions, presumably driven by the varied population who walk in each day. Here are a couple of the not-so-common questions that this topic prompted.

**“Why do FPA in Australia recommend against depot medroxyprogesterone acetate (DMPA) “Depo-Provera”, Depo-Ralovera”) as a first line method of contraception in women younger than 25?”**

Medroxyprogesterone inhibits gonadotrophin production, which in turn prevents follicular maturation and ovulation.

The product information (PI) warns about loss of bone mineral density, with a particular warning for use in adolescent girls, because of the loss of bone mineral density (BMD) at a time when most adolescent girls will be

significantly increasing their BMD.

The other time during which caution is advised is for women aged over 46 as, for both these groups it is unknown how much bone mineral density is regained after discontinuation of the DMPA.

**A similar question is the effect of Implanon® (etonogestrol implant) on BMD and fracture risk.**

The PI and available studies have concluded that the BMD in users of Implanon® is not significantly altered from those using non-hormonal methods (an IUD) or levonorgestrol implants.

The explanation provided in the PI is that the action of etonogestrol is to inhibit ovulation but not completely suppress ovarian activity,

and that oestradiol levels are maintained similar to those in non-users.

Although the data implies that Implanon® does not affect BMD; further clinical trials are needed before definitive recommendations for clinical practice can be made. The studies have not looked at assessment of fracture risk over time, once the implant is removed, or the effect in adolescents and perimenopausal women.

**“Why is Livial® not included in NPS material on specific therapy for osteoporosis?”**

Livial® is tibolone, a hormonal agent with oestrogenic, progestogenic and androgenic properties with approved indications of short-term treatment of symptoms due to menopause and as second line therapy for prevention of BMD

loss in postmenopausal women at high risk of osteoporotic fractures.

A study specifically designed to determine the effects on osteoporotic fractures of tibolone 1.25mg (LIFT study) was terminated after 2.75 years.

Women treated with tibolone showed an increased risk of stroke compared to placebo (4.26 cases/1000 woman years versus 1.64 cases/1000 woman years).

Thus tibolone, along with other forms of hormone replacement therapy, should not be used in postmenopausal women for the sole purpose of reducing fracture risk.

References are available on request.

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## Cardiologist

**Dr Krishna Kathir**  
MBBS Syd (Hons), PhD, FRACP, FACC, FCSANZ

**Consultant and Interventional Cardiologist**  
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# Make no bones about it

**50% of women and 33% of men over the age of 60 will develop an osteoporotic fracture, costing roughly \$7.4 billion per year. Continuing the theme of osteoporosis, HMR Pharmacist, Karina Bronska, discusses some local bisphosphonate misadventures.**

Mrs AB, 92 years old, lives at home alone. She is legally blind due to AMD. She takes her medications from a dosing administration aid twice a day; in the morning at breakfast and in the evening with dinner.

The risedronate 35mg tablet is packed with all the morning tablets and Mrs AB has been taking it together with breakfast as well as all the other tablets.

It would be almost impossible for the patient to distinguish the risedronate from the other morning tablets.

Bisphosphonates should be taken away from food and other medications as the acid environment caused by food in the stomach will destroy the bisphosphonate.

After the review was done, it was arranged for the risedronate tablet to be placed in a separate column in the dosing administration aid (marked 7am) on Mondays only and for the other morning medications to be placed in the next column (marked 8am).

Mrs ER, 75, also was receiving risedronate for osteoporosis. Actonel therapy was recently changed to Actonel Combi, and although she used a dose administration aid for her regular medications, this was not added.

As Mrs ER had been accustomed to taking the risedronate tablet once weekly, she continued to

follow this regimen with the Actonel Combi regimen, (one yellow risedronate as well as the six blue calcium carbonate tablets.)

Thus the risedronate was being taken every seven weeks! Mrs ER was explained the correct dosing of Actonel Combi and encouraged to dose these from her dosing aid.

## Other HMR findings regarding bisphosphonates

Several patients have reported severe chest pain after bisphosphonate doses, that is after lying down or bending following the dose.

In two cases this pain was mistaken for angina and ambulance assistance was sought.

Frequently, the tablets are taken with breakfast. If the tablet is missed, some patients do not take another dose until the following week, rather than taking it the next day.

Often, patients taking once-weekly tablets forget to take the weekly dose.

This can be verified during a Home Medicines Review by assessing prescription data from the patient's pharmacy and establishing an adherence percentage.

Studies on rates of adherence to administration requirements with bisphosphonates report that up to 52% of patients are not complying with at least one absorption instruction. Recently, many patients have ceased taking bisphosphonates due to negative media coverage. Often this is not communicated to the GP.

## How important is it to follow the administration instructions for bisphosphonates?

Both oral bisphosphonates have very low bioavailability; that is, less than 0.7%.

This is decreased substantially if taken with food so that the



amount absorbed from a dose of a tablet taken within 30 minutes before food is consumed or less than two hours after, is negligible. Also, concomitant administration with coffee or orange juice reduces the bioavailability by approximately 60%.

In the clinical trials demonstrating a positive effect, dosing occurred 30 minutes or longer before the first meal or beverage of the day or two hours or longer following food or beverages at other times of the day.

Karina Bronska  
kbronska@idgp.org.au

bisphosphonate

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# Brokering what ain't brokered.

In response to the workforce shortage, the Division's dual stream strategic direction is to support local general practices in the business of general practice and to augment primary care services where shortages are particularly acute. In this article, Lauren Hickson describes the success of the Division's first integrated mental health service.

The Division runs a spectrum of clinical services.

Engaging our own local GPs, the **headspace** youth practice, targeted to the health needs of young people who rarely engage traditional general practice, is at one end of the spectrum.

At the other is the Clinical Psychology Service, run from four different sites, but well removed from the day to day milieu of general practice.

In the middle is the mental health service run from five clinical rooms at Kiama Hospital integrating patient care delivered through a psychiatrist, a mental health nurse, clinical psychologists and a community nurse coordinator.

This service is the first of three developed to coordinate medical and broader community care as well as patient self management under the banner of ABHI (Access to Better Health Initiative).

ABHI is jointly funded by the Commonwealth

Government and the Area Health Service, and jointly managed by the Division and Area Health.

It aims to integrate primary care services, building multidisciplinary teams to relieve workforce pressures faced in primary care.

A milestone partnership with SESIAHS has and is still emerging through ABHI, which brings a new era to the way the Division does business through a brokerage role negotiating service pathways on behalf of local GPs.

With a mental health service only a phone call away, for Kiama practices, 2009 will see an expansion in clinical services local to their area.

Models of care for metabolic and respiratory disorders will enable GPs to refer patients for team-based assessments, treatment options and advice, care coordination and group and individual services.

It is planned that in 2010 these models will be replicated more broadly across the

Illawarra as an emerging element of the Division's clinical service stream.

## What makes ABHI different?

- Services and referral pathways are tailored to respond to the needs identified by general practice, hospital physicians and allied health service providers
- Coordinated multidisciplinary primary and secondary care teams— team work is key to streamlined, quality driven patient care
- Care coordination – a personalised link to communication with local practices and a means of monitoring patient compliance.

The Kiama/Gerringong GPs have been integral to the project development and the success of the service to date.

With thanks to the referrers, there have been in excess of 500 occasions of clinical service delivered to Kiama residents in 2008.

Lauren Hickson  
[lhickson@idgp.org.au](mailto:lhickson@idgp.org.au)

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# Planning for a Pandemic

As the backbone of primary care, the challenge for General Practice in planning for an influenza pandemic is particularly great. There can never be a “one size fits all” plan. In this article, epidemiologist Phillipa Binns argues that acting locally by preparing yourself and your staff for a potential influenza pandemic is the most practical and useful action possible.

## National Planning

The Department of Health and Ageing (DoHA) is revising the Australian Health Management Plan for Pandemic Influenza 2006 and has tasked the RACGP to develop a GP Pandemic Education Kit.

## State Planning

Over the last year the NSW Health Biopreparedness Unit has held meetings with delegates of organisations that represent general practice interests.

These meetings have provided input into draft GP policy and planning documents.

Further consultation and comment will be sought.

In the meantime NSW Health information resources can be found at [www.health.nsw.gov.au/publichealth/pandemic/](http://www.health.nsw.gov.au/publichealth/pandemic/)

## South Eastern Sydney Illawarra Health Service Planning

Valuing the importance of local relationships between network facilities and general practitioners to improve health service provision, each Division of General Practice has been invited to participate in local planning at their SESIAHS Network.

## Other professional organisational planning

The RACGP has prepared useful resources, especially their “Prepare your practice plan – now” poster at [www.racgp.org.au/pandemicresources](http://www.racgp.org.au/pandemicresources).

SESAHS is also keen to assist

Divisions to adapt the plethora of national, state and local planning into locally relevant and practical information for their GPs.

## What you can do to prepare for an influenza pandemic

- ♦ Appoint a practice pandemic co-ordinator
- ♦ Keep up to date
  - ♦ see websites mentioned above
  - ♦ ensure practice contact details are current with the Division
  - ♦ have a broadband internet connection
- ♦ Review infection control measures
  - ♦ identify isolation areas in your practice
  - ♦ implement alternative triage techniques (eg by phone; in car park)
  - ♦ waiting room respiratory etiquette implemented
  - ♦ learn to use personal protective equipment (PPE) correctly
- ♦ Vaccinate for seasonal flu and pneumococcus
- ♦ Train all staff
- ♦ Plan your business continuity
  - ♦ review workload division

and workforce particularly with respect to staff absenteeism

Remember, someone with avian influenza may present tomorrow!

Dr Phillipa Binns  
Medical and Biopreparedness  
Epidemiologist

## NEUROSURGEON

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# Reflections

To those few odd medicos spotted at the theatre when they might have otherwise been gaining valuable CME points; it now seems that an upbringing in a medical household and a degree of success in the Arts are not entirely mutually exclusive concepts after all.



Dr Mark Condon

Testimony to this was the recent artistic and (more astoundingly) commercial success of a theatrical venture, a new musical comedy written by 23yr old Danny Condon, son of Albion Park GP Dr Mark Condon.

The show "A Grave Affair" was produced with IPAC and Merrigong Theatre Co.

It ran for four nights playing to full houses and receiving much acclaim (not just from his father). A comedy in a graveyard "Police, a priest, a gold digger, a dead guy and a few dirty secrets..... A classic whodunnit with a satirical sting".

Danny, who had been winner of the 2006 Unhinged Short Play Festival was commissioned to extend and produce the play.

Keep an eye out for So Popera's next musical ("General Practice, The Musical").

No CME points (doubt any drug company interest would meet the guidelines) but a chance to support a local lad defying the odds at this stage.

And, so far, keeping his dad's house and practice off the market!

As famous as Danny is becoming, he is, of course, yet to catch the public eye the way his dad has.

Touted by his army of patients, Mark was awarded the Illawarra GP of the Year Award at the recent AGM.

Celebrating with the Practice of the Year, Dapto Family and Medical Practice, Mark was quick to exploit the marketing advantages of the Award, promising to raise his fees!

Patient adoration aside, Mark runs a sophisticated practice, employing three practice nurses, engaging GP Registrars to cope with patient flow and taking two medical students at a time. As one patient noted, "He is an extraordinary caring Dr who always gives 120% to provide an efficient service".

Perhaps there might be a small contribution from the Practice Manager in managing that efficiency gain, Mark?

Mark's also made the decision to involve his practice in the Australian Primary Care Collaborative; one of five practices chosen to be involved in the first wave of funding in the Illawarra. Busy boy.

However, his general practice priorities are fairly universal. To use his words, "I'd like to advertise that general practices provides such a unique calling to those that might be considering it because, boy, do we need some more."



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# Dealing with Staff Complaints

Dealing with staff complaints supportively and constructively makes good business sense. It supports sound clinical governance and builds a supportive and encouraging work environment. It can also help an employer fulfil their legal obligations to their staff. In this article, Nicola Bunt, HR Manager for the Division, gives some practical suggestions on handling staff complaints.

All employers have obligations under occupational health and safety and anti-discrimination laws to their employees.

These obligations can be met, in part, by an effective, fair and consistent approach to staff complaints or grievances. When dealing with staff complaints you may wish to consider the following:

- Promote an open and constructive workplace culture where it is widely known that feedback from staff, including complaints, is encouraged and genuinely viewed as an opportunity to learn and improve the way things are done.
- Deal with complaints promptly and informally where possible. Complaints do not need to be put in writing. If you can genuinely listen to, and talk through a complaint, it can quite often be resolved within minutes.
- Follow through on any actions prompted by the complaint. Investigate, research as required, determine appropriate course of action, and feed back findings to the complainant.
- If possible, involve the staff member in resolving the matter. Find out what the desired outcome is; benefit from the staff member's particular expertise or insight in identifying possible solutions.
- Listen for any underlying

issues. Sometimes an initial complaint will not convey the whole picture.

Ask questions and clarify messages to ensure you identify the real issue.

A complaint involving another staff member raises additional considerations although the need for a supportive and constructive approach remains unchanged.

Often the best approach to these complaints can be to encourage the parties involved to resolve the matter directly with each other. Consider coaching the complainant in how to approach the other staff member directly and in a constructive manner.

Direct resolution is not always appropriate, however. The complainant may not be comfortable with this, the circumstances may be too sensitive, or the complaint may be too serious (in which case a more formal investigation may be required).

When approaching a staff member who is the subject of a complaint it is important to remain impartial. Approach them confidentially and in a non-threatening way, keeping in mind that they are entitled to know the substance of the complaint (keeping to the relevant facts) and where the complaint came from.

Listen carefully to their response to the complaint and ask for


their input on an appropriate resolution. Let them know the proposed resolution once this is determined. Complaints that cannot be resolved informally should be escalated and a more formal approach taken, for example, investigation or mediation.

Most complaints though will not reach this stage. When staff feel their complaints are properly

heard and genuinely responded to, the matter is far more likely to be satisfactorily resolved, and their relationship with their employer all the better for it.

With this edition we have enclosed guidelines from the HCCC for handling patient complaints.

Nicola Bunt  
HR Manager  
nbunt@idgp.org.au



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# Taking Care of Business

In a global, national and local GP shortage, solutions aren't quickly at hand. In Taking care of Business, Practice Support Officer, Lauren Hickson, summarises initiatives available to attract GPs to our region.

## Area of need

The Area of Need program is a short-term strategy governed by NSW Health.

Unlike District of Workforce Shortage, Area of need does not, in fact, refer to an area but rather refers to a specific position that remains unfilled after recruitment processes have been unsuccessful.

An 'area of need' position may be granted upon successful application to NSW Health. Employees under area of need positions are usually overseas trained doctors who have not yet completed the AMC (Australian Medical Council) requirements or the RACGP fellowship exams successfully.

Area of need positions are determined based on need and evidence of labour market testing.

Illawarra practices have experienced difficulties in establishing area of need positions because of our metropolitan classification.

Despite an average success rate of 29%, many local practices have recently applied for area of need positions.

To apply for area of need, a practice needs to provide evidence of labour market testing.

This includes placing a total of four advertisements over one month between a national and metropolitan daily news paper and one advertisement in a medical specific newspaper (e.g. Australian Doctor).

You will also need a letter of support from the IDGP and documented evidence of need.

The application form can be downloaded from NSW Health at <http://www.health.nsw.gov.au/othp/> and the IDGP is happy to support you through this process.

## District of workforce shortage

The unmet needs of the Illawarra community have been recognised through the Commonwealth's District of Workforce Shortage Initiative (DWS). In theory, this means that the Illawarra has been defined as a geographic area in which the general population need for health care is not met.

In practice, this means that for practices without area of need status;

- Overseas trained GPs with qualifications equivalent to Australian training (i.e. VR) may fall under the Strengthening Medical Initiative where the Commonwealth will waive fees incurred by a recruitment agency.

The position must be for a minimum of 12 months, the doctor must have not worked in Australia before and is not Australian trained.

The AMC only recognises the FRACGP equivalent as those having undertaken a similar level of training in Canada, the UK and NZ, enabling these doctors to enter Australia as vocationally registered GPs.

- Overseas trained GPs who do or do not possess Australian equivalent training requirements may seek to work in the Illawarra under employer-sponsored visas.

This process can be lengthy and accompanies costs of approximately \$10,000 to sponsor but many consider it worth the effort and cost.

- Overseas trained doctors as temporary and permanent Australian residents can attract Medicare rebates. This is not normally so for areas not deemed as DWS.

The Division is committed to building and retaining the medical and nursing workforce in the Illawarra. For further information or advice, please contact us on 4226 7052.

## Links

Area of Need—

<http://www.health.nsw.gov.au/othp/>

District of Workforce Shortage—

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforce-otdt-index.htm>

Information on employing overseas trained doctors—

<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/employers-sponsoring-an-otd-lp-1>

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## Dr Katherine Brown

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# Electrons Behaving Badly

Adware, spyware, malware and viruses are part of the IT landscape. In his last article for the Division, OTIIS' Troy Smith makes us wonder why we ever gave up papyrus.

Malware is essentially the broad classification for all malicious software installed on your pc from an external source without your consent or knowledge. It is a broad term covering viruses, spyware and adware.

Spyware is software installed, usually unknowingly by the user, onto computers to intercept or take partial control over the user's interactions without the user's consent. As the name suggests, it can spy on a user's usage of the computer but it is not limited to just that.

Spyware can do just about anything from making your computer run slowly through to changing computer settings to stop certain functions, software or even hardware working on your pc.

Viruses are well known to all computer users. A computer virus can have all the characteristics of spyware with the added feature of self-replication; it can be passed

around like the flu and quite happily jumps from pc to pc around a network (including the Internet).

Adware is any software which automatically plays, displays or downloads advertising material onto a computer after an application has been installed or while a particular application is in use.

All malware work in similar ways. They are installed into hidden sections of your computer and are designed to start up each time your computer is turned on. Most of the more advanced applications are **very** well hidden and can actually pretend to be another more important application or be masked by important parts of the operating system (Windows).

As mentioned, malware can have very simple effects on your pcs from popups and advertising appearing on your screen, spying on your computer habits, raiding your hidden files, stealing passwords or files, or causing problems with software and hardware.

Some programs that advertise that they

remove specific malware are, in actual fact, malware programs too!

So in conclusion, you need to be very diligent about your home and office network/pc security. As a rule of thumb, if a popup or email appears that seems too good to be true, **don't click on it.**

Stay away from websites that look or seem a bit out of the ordinary and be very cautious when you are told you need to install a special program to view a website.

Make sure you have virus/malware protection installed on your machine AND ITS UP TO DATE – malware is changing and being invented every day and new updates are released regularly to combat them.

For any assistance or advice in implementing, upgrading or reviewing your pc/network security or help if you think your pc is infected feel free to contact our friendly OTIIS helpdesk to discuss your options.

Troy Smith  
itteam@idgp.org.au

## 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 or two evenings per week over 18 weeks.

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- ◆ Contribute to OHS processes

On line training available at [www.southernpath.com.au](http://www.southernpath.com.au)

Please contact Training Co-ordinator Janelle Morris on 02 4224 7464 or email [Janelle.Morris@southernparth.com.au](mailto:Janelle.Morris@southernparth.com.au)

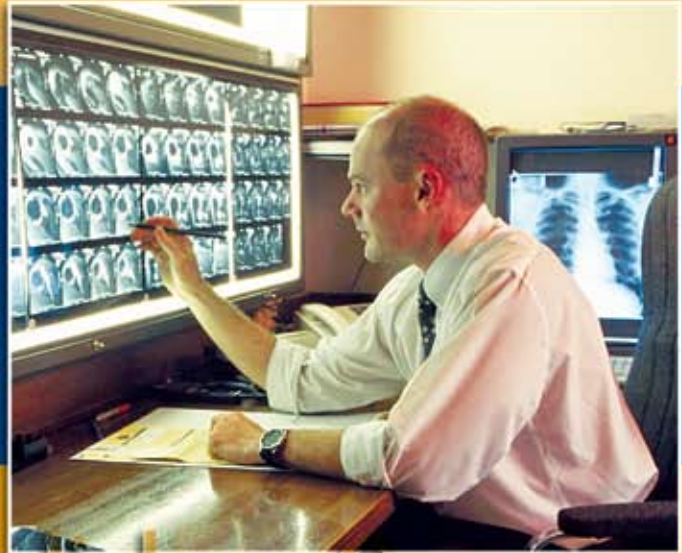


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Medical Imaging



# Illawarra Radiology Group



**Online Medical Image Delivery**  
Email: [Passport@irg.net.au](mailto:Passport@irg.net.au) for access details



**WOLLONGONG**

383 Crown Street  
8.30 — 5.00pm, Mon — Fri  
9.00 — 12.00pm, Saturday  
Ph: 4228 7888 Fax: 42271409

**CORRIMAL**

Shop 3, Railway Street  
8.30 — 5.00pm, Mon — Fri  
Ph: 4285 2119 Fax: 4285 3186

**SHELLHARBOUR**

Suite 1, Professional Centre, Stockland  
8.30 — 5.00pm, Mon — Fri  
Ph: 4296 7222 Fax: 4296 3188

**WARRAWONG**

Shop 101, Ground Level, Westfield  
Shopping Town (Cowper St entry)  
8.30 — 5.00pm, Mon — Fri  
Ph: 4274 6855 Fax: 4274 5363