FAMILY DOCTOR WEEK SPECIAL EDITION

CANBERRA Doctor

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Prof Nick Glasgow: the Joy of General Practice

BY SOUMYA JYOTI

"To me, the great joy of general practice is getting to know a group of people over time and getting insight into their individual lives," says Professor Nicholas Glasgow, general practitioner, researcher in the field of family medicine and, until December of last year, Dean of the ANU Medical School.

"General practice provided me with a richness, in a relational sense, that couldn't come from interacting with a patient over the course of just one episode of care."

By his own admission, Nick Glasgow's medical career has been guided, both clinically and academically, by this simple truth.

In light of Family Doctor Week, we consider the opportunities general practice has provided Prof Glasgow. As he readily admits, at the start of his career he could not have envisaged becoming dean of a medical school, "When I was at medical school, or even when I was working as a GP after leaving medical school, If you'd said I would be working as Dean of the Australian National University I probably would have fallen around laughing. Because it wouldn't even have been on my horizon of things I wanted to do – but the way my career has unfolded, one thing led to another and there it was."

The combination of compassion, taking opportunities when they arise and hard work are recurrent themes in Nick Glasgow's life.

Early days

Nick's early years were spent in his hometown of Auckland. The son of a distinguished local neurologist, he graduated from the University of Auckland in 1981 and after his early post-graduate years, commenced training in paediatrics.

Looking back on those days, Nick reflected that after a while "the thought of only ever seeing children for the rest of my working life made me question whether paediatrics was really for me. In the end, I thought I'd prefer to see more breadth than paediatrics offered."

As it happened, an opportunity to join an established family practice in Auckland arose and that proved decisive, "When I got that call, an offer to work in general practice, I was like 'yes, that is what I'd like to do'. So I ended up going into general practice and it's a decision I've never regretted."

The Auckland GP

Nick joined the RNZGP in 1987 and gained his Fellowship in 1991. He developed special interests in alcohol and drug addiction, aged care, management of dementia in a community setting and domiciliary palliative care. In addition, Nick was involved with the Doctors Health Advisory Service and served as a Police Medical Officer.

Prof Nick Glasgow, speaking at the ANUMSS Graduation Ball.

From 1990 until 1992 he was Censor for the Part 1 RNZCGP, with responsibility for the design, implementation and assessment processes relating to the examination. From this role it was a natural progression for Nick to become increasingly interested in the academic aspects of general practice including clinical problem solving, dealing with uncertainty and communication skills.

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Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

One of the main reasons Australia has our world class health system is the central role played by Family Doctors in patient care. More than 80% of Australians will see a General Practitioner at least once every year, and GPs are the most common point of contact when Australians become ill.

The vast majority of health problems are managed solely by GPs. The trusted relationship between GPs and their patients is fundamental to patient care in Australia, enabling safe disclosure of health care concerns and the provision of evidenced and patient-centred medical advice. Decisions about patients' health care are part of an informed and collaborative approach between patients and their GPs.

Family Doctor Week

Because of the amazing work done by Australia's GPs, the AMA celebrates their work with our annual Family Doctor Week. The purpose of this year's theme **"Your family doctor: all about you"** is to remind the Canberra community about the central role that GPs play in their health care. Having a regular GP is good for your health and helps ensure continuity of care – something fundamental to good preventive care.

The AMA wants Australians to understand that a GP's primary focus is firmly on what is best for the patient when it comes to preventive health, diagnostics and treatment, chronic disease management, and end of life care. When people have a trusted family doctor it is good for their health: those with an ongoing relationship with a family doctor have been shown to experience better health outcomes.

In this issue of *Canberra Doctor*, we feature articles highlighting different aspects of general practice for Canberra's busy doctors. Front and centre is a profile of the recently retired Dean of the ANU Medical School, Professor Nick Glasgow, whose background was general practice. Local GP and AMA President-elect, Dr Antonio Di Dio tells us what inspires him, Gaylene Coulton, the CEO of Capital Health Network, lets us know the latest from our local PHN and Dr Louise Stone pens an open letter to the next generation of aspiring GPs and other specialists. And much more.

Mental Health Minister, Shane Rattenbury.

When the chemistry is wrong...

Many of you will have read, with alarm, of plans for pharmacies to begin ordering pathology tests. This was an ill-conceived move, and I was very relieved to hear that Sonic Healthcare had decided to withdraw from pharmacy-based screening programs. The primary health care system we rely on is built around a medical model that can provide lifelong continuity of care.

For better or worse, the Government is promoting this principle through its Health Care Homes trials. Suddenly allowing non-medical health professionals to try to take over the work of experienced and highly-trained doctors would have been irresponsible at best, and frankly dangerous at worst. Pharmacists ordering pathology tests puts patients' health at risk, and increases medical costs for families.

As Canberra's doctors know well, specialized clinical judgement and many years of training are required to make decisions about whether patients need pathology tests. The interpretation of tests results and outcomes should be the province of GPs. Diagnostic tests, as well as other screening activities and health checks must only be conducted if they are clinically indicated, have an evidence base, and are cost-effective. It should be about benefit to patients. Pharmacists play a key role in the health system, and have a well-established collaborative role with GPs – ordering pathology tests is completely out of their scope of practice.

Mental health

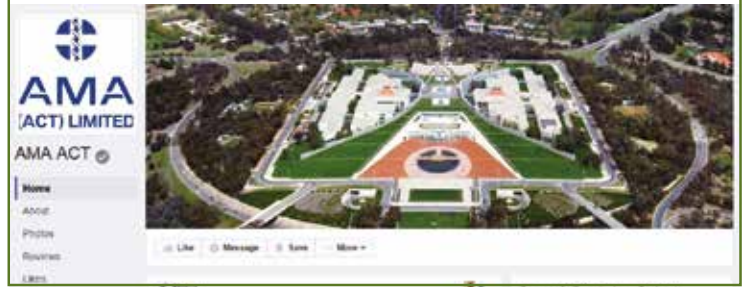
Over recent weeks the AMA (ACT) has been in contact with Mental Health Minister, Shane Rattenbury, about a number of serious issues that have arisen with mental health services in Canberra. While workforce has been the major focus, including the implications following the recent resignations of two psychiatrists from the adult mental health unit, there's no doubt that other staffing issues – access to child and adolescent services, and cover in the Emergency Department at Canberra Hospital – are also having an impact.

The ACT Government budget saw the announcement of a new 'Office for Mental Health,' there are some emerging concerns. Earlier this year, Minister Rattenbury made his initial appointments to the keenly-awaited Mental Health Advisory Council. The Council was set up to advise the Minister on matters including emerging or urgent mental health issues, and mental health policy. In appointing members to the Council, the Minister is required to ensure the Council included consumers, carers, and other members who have expertise in primary mental illness prevention and treatment, care or support.

With a total of seven appointments made by the Minister, it's extremely disappointing that he could not find room on the Council for either a psychiatrist or general practitioner. AMA (ACT) is determined to follow this matter up and I have written to the Minister asking for further information. Watch this space.

AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell. It's easy – just search for AMA ACT.



Q&A with Dr Rashmi Sharma OAM

For the second in our series of quick Q&As with doctors in the Canberra region we've asked Dr Rashmi Sharma OAM, leading local GP, Clinical Associate Professor at ANU Medical School, principal, along with her sister, of the Isabella Plains Medical Centre and AMA (ACT) Board Member, a few searching and not-so-searching questions.

Dr Rashmi Sharma OAM and family.

Q: Why did you pursue a career in medicine and why did you choose general practice?

I was the youngest of three girls and my parents had migrated to the UK in the 60's from India. My parents encouraged me to pursue a career that would be interesting, prestigious and, most importantly, enable me to be financially independent. I nearly actually chose law as a career (my father was an academic lawyer) but somehow, when I was 16 science subjects were chosen and so the story ends.

In terms of General Practice, well, I clearly remember sitting on the banks of the Brisbane River and tossing up between O&G and general practice. In the end though, my perceptions of O&G – endless night shifts, bullying and, ahem, "brown nosing" – set against training flexibility in terms of location and type of practice as well as the challenge of never knowing what you would be treating next – general practice won with ease.

Q: If you weren't a Doctor, what would you be?

Probably a lawyer. My father's background and with one of my two sisters a lawyer, I think that's the most likely alternative. Although I am sure I would have dabbled in a lot of things – like I do now! There is a side of me that likes gardening, collecting recipes that I never use (I have to put that in as my sister will be reading this), travelling , looking after animals , helping the needy and so who knows – I could have ended up as some sort of hybrid environmentalist or with MSF or Amnesty International.

Q: In your opinion, what are the most pressing issues facing the medical profession? And for your speciality?

I think there are many pressing issues for the medical profession – the limited health budget and using it wisely, the apathy and disunity amongst that policy makers exploit, the expectations of consumers, the perception that we are replaceable by other health professionals using flow charts and protocols and the oversupply in certain areas affecting training and also career satisfaction.

In terms of General Practice, I think we need to overcome the perception of being "second best" – sometimes expressed by our medical colleagues – and that all we see are URTIs and minor ailments. This perception then flows on to rebates that are embarrassing for the work we do. Until General Practice is appreciated by the profession and policy makers as a necessary part of health care and until we unite as GPs to present ourselves to policy makers, I have grave fears that there will be further erosion and fragmentation of primary health care with General Practice losing its pivotal and central role.

Q: Name an experience, event or person that has had a lasting influence on your medical career.

Oh there have been so many – where to start? From a patient point of view I have been privileged to observe the heroism of a family who lost their young daughter, offer solace to a father who's son was missing – later to be found drowned – and to share the joy of a young woman who fought off a sarcoma and went on to graduate as a lawyer and start a family. The journey we follow with our patients is the joy of General Practice.

From the academic point of view it is getting the emails out of the blue from a grateful ex-medical student saying they have completed their specialist training and thanks for the teaching.

From the policy point of view I think the 3 Chairs of the PBAC I have worked with – Lloyd Samson, Sue Hill and Andrew Wilson – have taught me how to balance evidence-based health policy decisions involving billions of dollars but still be compassionate to patients suffering from terrible illnesses.

As a patient undergoing treatment for my second cancer, I was fortunate to be treated by the late Chris O'Brien, the kindest doctor I have ever seen (and I've seen very many). He told me on day two post-surgery how great I looked – which was definitely not the case – but it made me realise that a simple few words could make me feel so much better and optimistic. Now I make a point of complimenting and encouraging those who come to see me realising just how comforting a few simple words can be when you're feeling low.

Q: You completed your medical degree in London – is there anything in particular you miss about living and studying there?

Oh yes – Marks and Spencers Food Hall! And just the buzz of growing up and being educated in London. The culture, and acceptance of being different – I am still dismayed by the racism and ignorant comments I sometimes experience in Australia, the frequency of which waxes and wanes with the political climate.

Q: What would you say is the most embarrassing moment of your professional career?

Mmmm there have been a few – falling off my chair mid-consult as I wheeled across my room was met by my patient roaring with laughter and leaving me there to help myself up.

Another time, telling a patient to say "ahhh" while doing a pap as I had seen a lot of tonsillitis that day and was on a bit of an autopilot. While she kindly obliged, I hurriedly advised it was a good way to relax the pelvic muscles and then had to confess!

Family Doctor Week 2017 – So what inspires you now?

BY DR ANTONIO DI DIO

Yes, well. The less said about inspiring article titles the better, I say. Nevertheless, a big welcome to our special week, a great time to reflect on how we got here in this important and wonderful profession, and what keeps us here!

Dr Antonio Di Dio, finding inspiration.

I started work early this morning, looking for what still inspires me. I'm told that in In 1960, when asked by a young BBC interviewer what kept him writing, Evelyn Waugh replied "the ongoing fear of poverty, my dear ".

Patient 1

Gee, I hope we can do better. Anyway, patient one arrives, late, grizzled, and after having the usual checks asks if I would mind getting a mole looked at. It's iffy so I get my colleague next door, very good at this sort of thing, to have a peek. I pop in to see our beloved pocket rocket, Dr Sporty.

She's just arrived on a bike thrice her size, looking like Annie but swinging like Rocky. The bike looks brand new because she never really rides it, just carries it over her head when running (to get a better workout), like some terrifying micro-Amazon. She's zipped over 20kms from her earlier job, giving anaesthetics.

I don't ask her about the kangaroo in her room but clearly they've been boxing. We've spoken about this sort of thing before. The roo is happy but exhausted, so Sporty tells him to rest and recover while she sees another patient. Note to self – do a push-up. Learn more about skin. Be nicer.

Patient 3

Patient three has seven simple things, one impossible fascinoma, no way of paying an account, a personality disorder, and then her real problems commence. Needing fiddly bloods and delicate personal handling next week, when I'm away on holidays. Blowing into a paper bag, I ask The Professor to have a look so she can follow my patient up next week.

The Prof holds my hand and explains all the big words from the path report, then calls the pathologist to explain them to him. She saves a few thousand for Medicare in unnecessary tests with a diagnosis worthy of House, then holds hands with the patient and looks into her eyes with a piercing kindness that tells her that someone understands. Patient is thrilled, follow up for next week is sorted. Note to self – be a bit smarter. And nicer.

Patient 9

The morning goes fine till patient nine gets a cut. While stitching it up I notice a little black lesion that needs removal immediately, and I'm booked out till the next Democrat administration.

Wonder Woman shows up to fill up the liquid nitrogen and waves hello, impossibly cheerful, machine-like in punctuality, brilliant in a way that no human could be. I ask if she would be ok to excise this lump tomorrow or this week sometime. In mid-stride she has a peek, makes the diagnosis, and agrees to whip it out tonight, just before ducking home, making a perfect meal, running to Yass and back then polishing off the Great Australian Novel. Note to self – try to develop some awesomeness, and be nicer.

The downhill run

OK, after that I'm sailing successfully solo. Twenty odd years doing this I do NOT need to lean on my colleagues every five minutes. I'm an independent guy. All I needed this morning were 8 quick phones calls to mates and 2 texts. And a snail mail. And one fax telling me to halve a dose of something unpronounceable. But other than that – totally solo.

Lunch passes al desko with notes and paperwork. The Prof is giving a speech online to a bunch at The Hague, hanging on her every word, while Wonder Woman's husband has popped in with the baby so she can quickly feed him in between lunchtime chin ups. We all hear Sporty in her office shouting "Get up, ya wimp" to some punch-drunk marsupial but pretend not to.

Patient 19

Meanwhile patient 19 arrives for tear duct control. She needs support and patience, from someone who has some sort of magic in her calm voice that oozes confidence and calm. Tomorrow I am away and she needs someone calmer than Buddha and smarter than Tesla . Um? Yes – Dr Purls kindly agrees to help.

Purls has temporomandibular joints that apparently work quite well, but who is so classy that they have almost never been used. They say that, when still young, she was involved in a tragic accident with a liberty print shirt, a pair of R M Williams boots, and

a navy overcoat, and when the hospital accidently gave a transfusion of pure White Linen, she was doomed to a lifetime of being mistaken for Grace Kelly or Princess Diana. She has never been seen without pearls, or noted to raise her voice or be ruffled by anything. The patients love her. Note to self – be less goofy. And nicer.

Patient 22

Patient 22 needs a dressing and ECG quick smart. Nurse Diesel says yes but growls that low husky way when she's not been fed for some time. I don't get too close and she does what's needed. I never make eye contact. We understand each other. Note to self- give in less to fear.

And I'm getting closer to learning something about what inspires me. But not till Mrs Smooch needs advice about a procedure next week. The very brilliant Dr Saffron has arrived and her door is open – I catch her and beg for help – and she sorts it all out it a minute. At the same time her hands cradle a mortar and pestle as she combines ancient recipes for curries that would make you weep with joy, checks path results on the screen, and fields calls from her husband, one of the smartest men I know, asking how the roll-a-door works. He is my brother in non-medical ineptitude. Note to self – be multi-skilled, and humble. And nicer.

Patient 24

Patient 24 needs complex issues addressed and I need to know what the medical board would do. Dr Bunny skis in her dreams but she's also the most authoritative doctor in the town. All seek her wisdom, I live next door to it. She sorts it out with a smile before telling me about ski conditions in Copenhagen and what AHPRA need her advice for this week. Note to self – look at all the amazing careers within careers in medicine.

Finally Mr A presents, booked for spirometry. Sporty and Wonder have both gone home. The Prof is online to Harvard and the others are busy. I must face Nurse Diesel – alone. I creep in. She looks up from her chair in the corner. She's holding Dr Saffron's mortar and pestle. She likes to crush things when I make requests.

This time, it's a goniometer. Quick thuds are followed by a cracking sound. She smiles and kindly says "Of course, dear beloved colleague". She's always in a good mood after the "crack" sound. Problem quickly solved, patient better. She hugs me and says I must not give in to fear. Note to self – do not give in to fear.

My Inspiration – Every Day

I look around and wonder what inspires me every day. Yes, it's my family and friends, and yes it's the patients but today and every day it's the amazing people I work with. They inspire me to do better, and they make me enjoy the work we do so much more. Welcome to family doctor week – I think they are awesome!

2017 AMA National Conference

Earlier this year, I had the opportunity to attend the 2017 AMA National Conference in Melbourne. It was three days of panel discussions, political addresses and networking that ultimately came together to be a great weekend.

John Zorbas and other panellists discussing doctors health.

Political leaders

The conference started off with a series of speeches from the leaders of the major political parties. Health Minister Greg Hunt expressed his gratitude to our profession, the lifting of the Medicare freeze, and perhaps most importantly, he announced $47 million suicide prevention initiative with $1 million being set aside specifically to support the healthcare workforce.

Opposition Leader Bill Shorten and shadow Health Minister Catherine King delved a bit deeper into the planned Medicare freezes, highlighting what a small proportion of the health budget was allocated to increase Medicare rebates and to express their dissatisfaction of the amount of time it would take to re-index individual Medicare items.

Leader of the Greens, Senator Richard Di Natale (a former GP) spoke about the gap between indigenous health and the lack of substantial improvements in this area.

Message from the PM

The political speeches were rounded out on Saturday with an address from the Prime Minister Malcom Turnbull. He focussed on the Government's commitments in the budgets to health and medical research.

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AMA National Conference...*continued*

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Like a lot of people, my eyes do tend to glaze over at talks of politics, but I must admit that I found it humbling to be addressed by the political leaders of our country.

I think it says a lot about the respect politicians have for the AMA; that their most senior members will accept an invitation to come speak to us at our conference.

I was able to see four of the panel discussions, focussing on organ donation, infectious diseases, doctors' health and health policy. What struck me about all the sessions was the diversity of their members, from senior politicians such as Ken Wyatt MP to leaders in industry and senior doctors, patients to doctors in training including our President of the Council of Doctors in Training Dr John Zorbas.

All of the panel sessions had a high level of engagement from the audience, with interesting questions and anecdotes shared. The DiT WhatsApp chat also let us discuss topics amongst ourselves in real time (often with hilarious comments!).

Doctors health

A recurring focus throughout the conference was doctors' health. Tribute was paid to Dr Chloe Abbott, an active member of the AMA. Dr John Zorbas submitted an urgency motion for the AMA to support the removal of mandatory reporting laws, which was passed unopposed (since then it looks as some changes will be made). Although this is one important barrier for seeking help, the consensus is that there is still much to be done within the culture and practice of medicine to look after ourselves and each other.

One such way to do this is engage a GP. The importance of primary care and the lack of GPs and generalist also came up repeatedly over the course of the conference, although there limited discussion on how we might remedy this issue.

Leadership dinner

A stand out event during the conference for me was the leadership dinner with keynote speaker Dr Bronwyn King (a quick bus ride to the venue gave me some time to get to know fellow AMA Members). Dr King, a radiation oncologist, has been pivotal in encouraging superannuation companies from divesting their investments in tobacco companies.

She recounts a story of her very first rotation as in intern, on a lung cancer ward. Fast forward 10 years and she offhandedly asks her financial planner what her super is invested in, and was horrified to find out four of the top five international investments were with big tobacco companies. Since then she has been campaigning to remove superannuation investments out of tobacco companies. Given that hundreds of thousands of children start smoking DAILY, and smoking causes significant health impacts – it is indeed a valiant effort.

Rebeka, left, with a colleague at the AMA National Conference.

Her work has led to the redirection of $6 billion of investment from the tobacco industry and she is now the Chief Executive Officer and Founder of 'Tobacco Free Portfolios'. Dr King has also started a Pozible campaign to help get her verified tobacco free badge up and running, you can donate by going to https://pozible.com/project/verified-tobacco-free

The weekend as a whole was whirlwind but enjoyable. I think past president of the DiT AMA council Danika Thiemt summed it up best when she said that "finding the AMA was like finding her people". All doctors care about our patients, but the AMA family cares about each other too.

Dr Rebeka Stepto is Co-Chair of the AMA (ACT)'s Doctors in Training committee, and an RMO at Calvary Hospital.

Doctors' health resources

Are you looking for a GP?

If you're a junior doctor or medical student and looking for a GP please contact AMA (ACT) and we will assist you to find a local GP.

Doctors' Health Resources online

AMA's Doctor Portal:
https://www.doctorportal.com.au/doctorshealth/resources/

JMO Health:
http://www.jmohealth.org.au/
Partly funded by DHAS and a range of other organisations.

Doctors Health Advisory Service
http://dhas.org.au/resources/resources-for-junior-medical-officers.html
On the DHAS website itself.

AMSA students and young doctors:
http://mentalhealth.amsa.org.au/about-the-campaign/
http://mentalhealth.amsa.org.au/keeping-your-grass-greener/

A GP's open letter to young doctors

BY DR LOUISE STONE

Dear Young Doctors

We get it. We really do. You know you ìshouldî have your own GP, but we are never free in the 5 minutes you have available between shifts on a Saturday afternoon, and besides which, you can prescribe your own Amoxil for the chest infection you've had for a week (and you can't possibly take a day off: no-one else does). And the last GP you saw for "just a script" had you in and out in 5 minutes, which seemed like a colossal waste of time.

Or maybe there's a deeper reason. Are you worried what a GP will think of you? After all, many senior "colleagues" treat you like something you scraped off the bottom of your shoe, so will a GP also think you're neurotic? Or weak? Or stupid? What will they say if you finally screw up the courage to talk about your despair, your sense of hopelessness, your feelings of dread when you arrive at work in the mornings? How will they treat you if they know about your secret drinking, or drug taking, or self harm? Or if they know how you suffer violence at home, every day, and feel utterly powerless to respond? Will they laugh at your fears and vulnerabilities, or worse still, will they ruin your career with a mandatory report to the Medical Board? Is it worth the risk?

We GPs have discussed this, and here's what we want to tell you. We worry about you. We think you should get the treatment you deserve. And we want to help.

You deserve respect and empathy

Doctors are people too. You shouldn't have to behave like a "normal" patient (whatever that is) and we shouldn't treat you differently to anyone else. After all, we adapt to the needs of the 4 year olds and the 94 year olds, the intellectually disabled adults and the lawyers. We ought to be able to get the communication balance right: you shouldn't have to pretend to be ignorant, we shouldn't treat you like you know everything (or nothing).

You should be allowed to be worried about your health. We understand that treating a young woman in palliative care for her ovarian cancer will change your level of concern about your own abdominal bloating. And we should take you seriously and not shame you for it.

We recognise that the word "resilience" can easily be translated as "suck it up sister and stop whinging". Or worse still, "your distress is your own fault because you're not coping well enough". Trust me, you wouldn't be in this job unless you were resilient. So, let's all acknowledge that the medical workplace is often toxic. It's not your fault.

You deserve quality care

Self-prescribing is not quality care. Seeing a different doctor every single consultation is not quality care. Seeing your best friend's dad (or your own) or seeing your GP supervisor is definitely not quality care. Try to choose someone you can see relatively regularly, especially if you have ongoing health issues. Choose someone you like and respect. It's worth booking in advance if you can. Trust takes time.

Good GPs will discuss and negotiate how you are billed, and how you can get in to see them if you really need to. They help you make decisions when you are overwhelmed and they make you feel comfortable so you don't need to edit what you say. Good GPs don't know everything, but they know where to find out and they're honest about the limits of their knowledge and skills. They know their network, and refer carefully, especially with issues like mental

health where a good therapeutic relationship is critical.

You deserve confidentiality

Every other patient expects this. You should too.

So let's get the Medical Board question up front: we only report if we feel the patients are at risk. If the risk is to you alone, mandatory reporting is not required except when sexual misconduct with patients or intoxication at work has occurred."

You can ask us the question if you need to: "in what circumstances would you need to report this to the Board"?

We don't think what you think we think

We have our own GPs, who we value. We get embarrassed too. We remember being junior doctors and we still struggle keeping our heads above water at times. We get stressed. We know what burnout feels like. And many of us have had our own battles with mental illness, chronic disease and substance misuse.

We are not just "experts in coughs, colds and paperwork". We know you are generally a healthy bunch, so you may not have seen us manage chronic and complex care, but we do. We know our profession is not perfect, we know you get inappropriate referrals from us sometimes ("patient is crying, please fix"). But remember, the slightly grumpy GP who rings to chase a discharge summary will turn their slight grumpiness into advocacy on your behalf if you need us too.

So seek us out. Talk to other doctors about their GPs. Come and see us for something simple to see if we are a "match" for your needs, before you need to seek care for the hard stuff.

It's time to get the treatment you deserve.

The Joy of General Practice ...*continued*

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An opportunity arises

In 1993, after ten years working full-time in general practice in Auckland, an opportunity arose for Nick to take up an academic appointment in the newly-formed Department of Family Medicine at the University of the United Arab Emirates.

Up to that point, both Nick and wife Jennifer had lived in New Zealand all of their lives but summing up the approach they took he says, "We looked at it and thought, well it could be an adventure, or of course it could all go south but if we don't try, we won't know."

So with four small children in tow, confident that if the move didn't work out something else would come up, the Glasgow family moved to the UAE and Nick was appointed an Assistant Professor in the Department of Family Medicine.

And as it turned out this was one of the most important decisions in Nick Glasgow's career.

An academic career starts

For four years, Prof Glasgow worked in academic family medicine in all its elements – teaching, research and provision of clinical services. The newly-formed Department of Family Medicine had attracted a number of prominent expat academic general practitioners from many parts of the world. Many of those academics in the Department became, not only colleagues but mentors.

"There was this group of people who were just extraordinary in terms of the richness of their experience of academic general practice and who had networks all over the world. They were prepared to share their insights with me, mentor me and back me," Prof Glasgow said.

"They were tremendously helpful in shaping who I became as an academic GP." he added of his colleagues in the UAE.

It was more than just medical knowledge Nick gained during his time in the UAE, "I think it opened our eyes to the world. I mean we thought we were pretty worldly living in New Zealand. But really we didn't know much at all." he reflects.

Prof Nick Glasgow, far left, with colleagues during his time in the UAE.

Nick Glasgow comes to Canberra

After four years in the UAE, 1997 saw the Glasgow family move to Canberra for Nick to take up the position of Associate Professor of General Practice at the Canberra Clinical School. In that role, he led the development of the community and rural programs for firstly, the Clinical School and then, when it started in 2002, the ANU Medical School.

In 2003, Nick was appointed Professor and Foundation Director of the Australian Primary Healthcare Research Institute. The research agenda of the Institute focused on health services research and the nexus between research evidence and policy formulation.

After the foundation Dean of the ANU medical school, Professor Paul Gatenby, stepped down in 2008, Prof Nick Glasgow was appointed to the role.

'Dean' Glasgow

Nick Glasgow was Dean of the ANU Medical School from 2008 until he officially stepped down at the end of last year. Of the ten years the ANU medical school has graduated new doctors, he was dean for nine of those years.

While Nick is clear that being the dean was overwhelmingly a rewarding experience, there were certainly challenges along the way, "All universities want a medical school believing it will add prestige and be a symbol of their success. When, however, they actually get a medical school they realise it needs to be cross-subsidised and is expensive to run."

From the new Dean's perspective, it was important that colleagues, fellow academics, and other senior university staff and external stakeholders saw the medical school as a necessary addition to the ANU; an opportunity to build on the university's already significant national and international reputation. Prof Glasgow readily acknowledges the difficulty for other academic colleges at the ANU to be giving up funding in order to subsidise the new medical school, "It was my role as Dean to articulate those arguments on behalf of the medical school, both with the university and with the health sector." he explains.

Despite its challenges, Nick's experience at the ANU was enriching and exciting; the opportunity to learn from and work with leaders across various disciplines and to tackle national and global problems and, within the medical school itself, the chance to see graduates doing great work.

The Future of medicine

When asked what he thinks of the future of medicine, Nick identifies the increasing presence of data in the therapeutic environment as key. He believes we are moving into what can be described as a "world of increasingly data driven care" which, in itself, is not a bad thing, unless data driven care becomes all there is, "If we lose sight of the relational aspects of medicine, I think we will lose something very important."

The trap may well be that data has over promised what it can deliver, "I'm not arguing we shouldn't embrace the advantages of big data, that should continue, but I am arguing that the delivery of good healthcare will depend on good human interactions, for a lot longer, I think, than some might feel."

What's Next?

While Nick Glasgow has already resumed active involvement in some longstanding areas of interest, one thing's for certain – he sees his future in Canberra. After more than 20 years living and working in the National Capital, Nick feels that it's home, "I've been very privileged in Canberra and yep, this is our home now."

Nick and Jennifer's four children are based in Canberra or Sydney so the family's close too.

Opinion: Good general practice and some other thoughts

A few reflections on the power of relationships for good general practice, the value of primary care and why we need to be cautious about ìimportedî policy changes.

"I was chatting to my hairdresser the other day. She had moved across town but when she needed a GP she still made the long trek across Lake Burley Griffin to her GP in the Tuggeranong area, "It feels like home" she said.

She had tried a GP in her new suburb in a practice with a good reputation but she had to tell her story again and they didn't know her. She preferred to go where she was known, where she had relationships.

GPs and practice staff build up relationships with their patients over time through minor and major illnesses. A patient may see a GP to get a medical certificate for their cold, for management of their blood pressure, for their frozen shoulder and maybe to check a new breast lump. The relationships formed are not only with the GP, but with the receptionist and practice nurse as well.

Relationships count

An established relationship means that when a patient has a niggling stomach pain they are much more likely to seek help early and the gastritis is diagnosed before causing a haemorrhaging stomach ulcer where an ED presentation and/or a hospital admission is the result.

Relationships are important

While some of the services GPs provide could also be provided by other professions, removing the delivery of those services from general practice removes the opportunities for relationship building that may prevent hospitalization in the future. If pharmacists, nurses and nurse practitioners are going to manage minor illnesses it would be best done in a general practice setting otherwise we run the risk of further fragmenting care.

Primary care paradox

The primary care paradox tells us that patients managed by a GP are less likely to achieve intermediary health goals such as lower HbA1C measures than specialists. However, patients managed by primary care physicians have better functional outcomes at lower costs than those managed by specialists and there are two possible causes.

The first is that the studies have produced an incorrect result, except there are multiple well conducted studies published in mainstream journals so that's unlikely. The second cause is that intermediary outcomes are poor measures of the value of primary health care. While this is more likely, there are few simple alternatives and the research does not offer conclusive answers.

Continued page 14...

Prof Nick Glasgow, left, with AMA (ACT) President, Dr Paul Jones in 2007.

Nick's other interests include his dedication to exercise – generally on his bike or giving the cardio machines a workout at his local gym and it's no surprise that anyone with a Kiwi heritage is going to remain a not-so-secret All Black supporter.

Now that's the best of both worlds!

Clinical practice

In terms of clinical practice, Prof Glasgow has returned to an area he's had an interest in since his early days as a GP in Auckland – palliative medicine, "although it's about people dying, palliative medicine is a discipline where getting to know the individual is fundamentally important. It resonates very much with me and what I like about general practice".

In its simplest form, Nick Glasgow describes both palliative medicine and general practice as "dealing with the human condition."

In his own words

Writing in the Canberra Doctor edition of December 2007, Prof Glasgow describes the approach he intended to take as Dean, an approach that again reflects those themes referred to earlier – compassion, opportunity and hard work:

"How important to the practice of medicine is the art of giving a sense of time and space to those with whom we interact, of conveying a sense of being valued and heard. Excellent science must remain the foundation of medical knowledge.

The translation of this knowledge into practice will necessarily involve new and often complex technologies. Healing, in its broadest sense, will be promoted when medical science and technology is applied with true compassion, and the ANU Medical School will not lose sight of this."

Thank you Professor Nick Glasgow.

Capital Health Network – working with you

BY GAYLENE COULTON, CAPITAL HEALTH NETWORK CHIEF EXECUTIVE

I believe we have a strong primary health care system in the ACT. The recent AIHW report "Admitted patient care 2015/16 – Australian hospital statistics" showed that the ACT has the lowest rate of potentially preventable hospitalisations in all three of the broad categories of acute conditions, chronic conditions and vaccine-preventable conditions.

The results demonstrate that general practice takes a holistic and proactive approach in the management of patients to try to prevent avoidable hospital presentations. You don't need convincing that general practice is the cornerstone of primary health care. We're proud to support **AMA Family Doctor Week 2017 – Your family doctor: all about you.**

Our local GPs continue to deliver high-quality care and provide such an important role in managing people with chronic conditions and keeping them out of hospital. Capital Health Network, through the ACT PHN programme, is working closely with general practices to provide them with tools and information to enable a whole-of-system approach towards improving the identification, assessment and management of patients with chronic disease or those at-risk of developing chronic disease.

Practice Development Program

ACT PHN's Practice Development Program uses a range of organisational development, project management and quality improvement methods to build the internal capacity of practices to implement new evidence-based models of service delivery. These often lead to improved patient outcomes, experiences and decreased overall costs of care.

Dr John Deery, Your GP@Crace and Your GP@Lyneham, said ACT PHN's QiData Program has been valuable. "It has been enlightening to have an independent agency analyse our data and has helped us to find areas where we can increase our services to patients in a cost effective way. We have also learnt through the ACT PHN team ways to help us overcome difficulties in collecting data. Asking patients about their ethnicity has been a particular focus area. Bench marking our practice against other practices has also spurred us on to improve and seek excellence."

Eleven local GPs recently completed a Clinical and Business Leadership in General Practice program delivered over nine months. The course was developed and facilitated by BMP Consulting and Rod Buchecker, hosted by CHN and supported by our General Practice

Advisory Council. A further program will commence in October. This course was just one of many offerings of GP education provided by the ACT PHN Continuing Professional Development Program.

HealthPathways

ACT PHN's HealthPathways is a quick to use online health information portal which GPs can use at point of care to guide best practice assessment and management of medical conditions. We now have over 300 pathways live, with another 100 currently in development. Through HealthPathways you can access up-to-date, locally relevant, high quality patient assessment, management and referral information when the patient is sitting in front of you. It allows you to enhance patient care and saves you time in consultations involving complex health care issues.

We're fortunate to have an expert team of experienced, local practicing GP Clinical Leads (Dr Janet Watterson, Dr David Gregory) and GP Clinical Editors (Dr Melanie Dorrington, Dr Jaclyn Moss, Dr Konrad Reardon, Dr Issuru Premawardhana, Dr Louise Tuckwell) overseeing the pathway localisation process, along with subject matter experts who are often specialists from a hospital department or in private practice. ACT PHN's HealthPathways is a collaborative partnership with ACT Health, SNSW PHN and SNSW Health District. To access HealthPathways, go to https://actsnsw.healthpathways.org.au

Support for Canberrans with a chronic condition

Another new initiative is our ACT PHN's Transitions of Care 12-month pilot program which aims to help Canberrans with a chronic condition ensure that they are accessing the services they need after being discharged from The Canberra Hospital. Our team consists of three experienced health care professionals with a range of community and ACT health knowledge who are identifying patients at an early stage of chronic disease diagnosis so we can minimize the impact and progression of the chronic disease for both the patient and their carer.

Our team is supporting people to better understand their condition and the support services availa-

ble to meet their needs now and in the future. They visit clients at home to help them and their carers link with and set up ongoing practical support. They also link eligible clients to condition-specific support groups and chronic care programs. Our team also explains to clients that their GP is central to managing their care and to monitoring changes in their chronic condition over time and that they should schedule a visit as soon as is practical.

There is a Transitions of Care Reference Group to oversee the program and Dr Trina Gregory and Dr Tanya Robertson are members of this group.

Pharmacist within General Practice Pilot Program

Over the past 12 months CHN, through the ACT PHN programme, has been examining the benefits of utilising non-dispensing Pharmacists in three local general practices: Isabella Plains Medical Centre, National Health Co-op and YourGP@Crace. Early benefits have included additional support for GPs in managing patients, freeing up GP time and increasing patient access, patient adherence to their medications and improved health outcomes. As the findings from the pilot have been promising, we've extended the pilot for another 12 months.

It's encouraging to hear Dr Joe Oguns, Medical Director at the National Health Co-op say "Having a Pharmacist in general practice has resulted in de-prescribing of medications which are not essential to patients' current health needs which reduces pill burden and improves compliance with important medications. It has also been beneficial in identifying and avoiding potentially significant medication related adverse events," said Dr Oguns, National Health Co-op Medical Director.

If you would like further information about these and other ACT-PHN practice support initiatives, please contact us on 02 6287 8099 or reception@chnact.org.au.

Canberra's First Medical Meeting

BY DR BILL COOTE

Before World War 1 about 1000 workers were engaged in building Canberraís basic infrastructure including the water supply and sewers. Construction of permanent housing and the first public buildings commenced in the early 1920s. By 1921 the population had grown to about 2800. Later in the 1920s public servants began arriving from Melbourne as the Provisional Parliament House neared completion.

An editorial in the Medical Journal of Australia (MJA) of December 19, 1925 reported: "On September 11, 1925, the members of the South-Eastern Medical Association gathered together at the Hotel Canberra, in the Federal Capital, and held the first organised medical meeting within the territory". The minutes book of the Central and Southern Medical Society (CSMS) for the years 1919 to 1950 is held by the ACT office of the Australian Medical Association and includes a detailed record of that meeting.

The CSMS and NSW BMA

The Central and Southern Medical Society was one of 17 local associations across Sydney and the country areas affiliated with the BMA. The CSMS had an annual general meeting and a committee met three or four times a year. The September 1925 Canberra meeting was a special general meeting.

Fourteen local doctors attended the inaugural Canberra meeting: two from Queanbeyan, one from Yass, five from Goulburn, one from Cooma, one from Gunning, one from Boorowa, and three from Canberra. The minutes book records: "Proceedings commenced about 4pm with afternoon tea served in the large smoking room which had been reserved for our use."

An interesting aspect is the involvement in the CSMS meeting of the NSW BMA. Dr Crago, the Honorary Treasurer of the Branch and Dr Adam Dick, the delegate of the Branch on the BMA Federal Committee attended the meeting. The BMA arranged for two Sydney specialists, Dr Dawson and Dr Lahey, to present papers on clinical issues.

The meeting commenced with a discussion of some specific medico-political issues referred to the meeting by the NSW BMA, this was followed by some local political business and then by Dr Crago presenting a report on the development of the NSW BMA Branch. The meeting concluded with the two clinical talks.

Annual meeting of regional groups with BMA

A representative from each of the 17 regions attended an annual meeting in Sydney with the NSW BMA Branch Council. The CSMS representative in 1925 was Dr English from Yass. At the Canberra meeting he received instructions on how to vote at the annual meeting of delegates to be held in Sydney on 2 October. Three issues were considered.

A proposal "emanating from the friendly societies" that "juvenile members" aged between 8 and 16 be treated at reduced annual capitation rates with the CSMS initially rejecting the proposal. Dr Adam Dick, from the NSW Branch, then suggested it would "show good faith" to support the proposal and that doctors would have "very little to lose by such new modification". The matter was left in the hands of the delegate to the State meeting.

Dr James Adam Dick, NSW BMA Federal Councillor, in uniform.

The meeting then considered a proposal from the South Sydney Medical Association that "more investigation should be made into the financial circumstances of patients applying for treatment in public hospitals." It was pointed out that "abuses" did exist but that no satisfactory method "of eradication" had been evolved. Again the matter was left in the hands of the delegate to the State meeting.

The third matter considered goes to the evolving tensions within the profession around the development of specialism and intra-professional protocols. The Northern Districts Medical Association proposed: "No member shall notify other members of the profession by means of a circular letter that he practices or intends to practice as a specialist in any particular branch of medical science provided that this restriction does not apply in the case of a member who does not undertake the immediate care of patients except those covered by his speciality and that such circular shall receive the sanction of the President of the BMA."

This was also left to Dr English.

NSW BMA Branch Report

Dr Crago presented "a very interesting address" that "dealt with the financial position and development" of the NSW Branch of the BMA. He had been an executive officer of the Branch for 37 years "a record, he stated, for the whole of the BMA".

Adjournment

"At 6.30 in the afternoon the meeting adjourned for dinner at which the members from Queanbeyan and Canberra acted as hosts."

Clinical Talks or "Scientific Papers"

Dr AL Dawson read a paper on eczema. He emphasized that it was

The Hotel Canberra, site of the first medical meeting in Canberra.

becoming more and more recognised that forms of dermatitis to which the name eczema was given were rarely if ever idiopathic. The removal of the cause of the irritation was followed by cure, although it was extremely difficult to discover the true cause. The use of other than very weak applications was a frequent cause of failure of treatment.

Dr HG Lahey read a paper on some of the more important complications of gonorrhoea in the male.

While this might seem an unusual issue for such a meeting, gonorrhoea was a significant medical issue among World War 1 veterans. The three volume official history of Army Medical Services in the War of 1914-1918 has a summary chapter on venereal disease which states "...it is necessary to face the truth that in none of the forces from the dominions, serving overseas and far from home, of which figures are available, was the proportion of admissions to hospital for venereal treatment less than 100 to every 1000 soldiers....the rate in the Australian forces was among the highest."

Dr Leahy, in his paper, made a plea for the use of the straight metal sound as opposed to the curved one in the treatment of urethral stricture. He advised that the essential factor in the treatment of gonorrhoeal arthritis was "massage of the prostate and seminal vesicles, if possible, twice a week for two months. This procedure had the effect of flooding the patient's system from time to time with an autogenous vaccine".

The meeting closes

The last entry in the minutes supports the view that the meeting was seen by participants to be of some historical significance: "Finally the President moved and had carried by acclamation a hearty vote of thanks to our hosts the Queanbeyan and Canberra members. Thus ended the first general meeting of a sub-branch of the BMA in the Federal Capital territory: and if the number of toasts honoured and healths drunk at its close is any criterion then indeed the meeting was a most successful one."

Urethral sounds c.1911.

This is an edited version of the paper presented at the inaugural meeting of the Canberra chapter of the Australian and New Zealand Society of the History of Medicine on August 17 2016.

Pee with ease

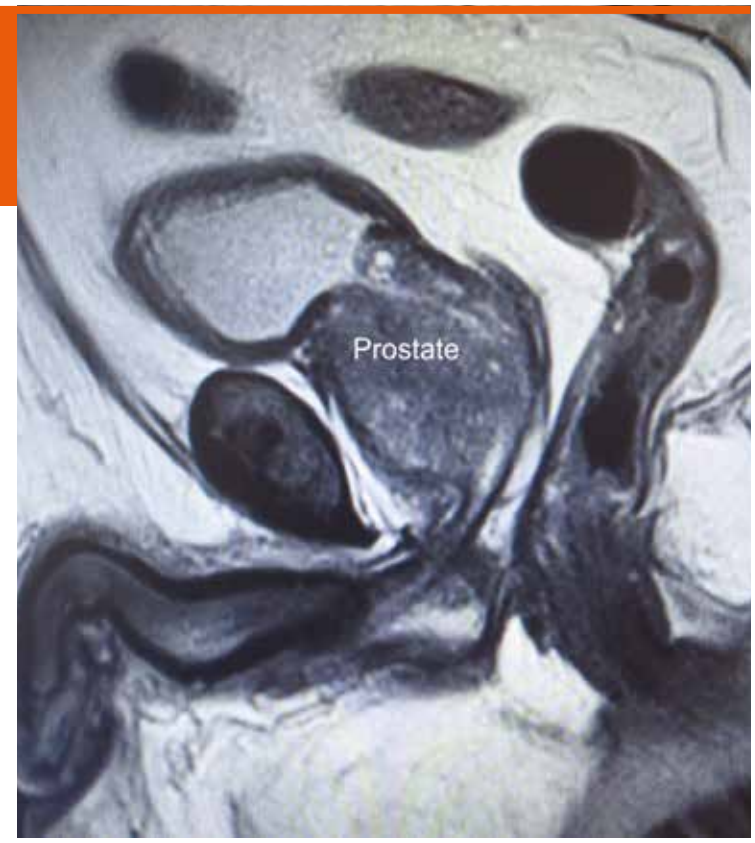
BY DR ROBERT ALLEN, MBBS, FRANZCR, FRCR, DDU

Benign Prostatic Hypertrophy (BPH) increases in frequency and severity with age with moderate to severe lower urinary tract symptoms (LUTS) in about a quarter of men in their 50s and half of men over 80. Medical therapy may be the first line treatment but successful long term management is often not effective and limited by side effects of dizziness, sexual dysfunction and depression.

Transurethral resection of the prostate (TURP) offered treatment for those failing medical therapy but was complicated by an incidence of incontinence, impotence and retrograde ejaculation. Minimally invasive techniques (MIT) have been introduced aiming to reduce complications and costs while trying to maintain the functional outcomes of conventional TURP and data on these techniques is emerging. Prostate artery embolisation (PAE) has come of age as a treatment for patients with BPH who do not find relief from medical therapy and are looking for a non-surgical alternative to standard therapy.

PAE is a day procedure performed by Interventional Radiologists and is analogous to uterine artery embolisation for symptomatic uterine fibroids. Arteries to the prostate are small and high level IR techniques are required to successfully occlude these vessels with 300 micron particles. With any embolisation procedure non target embolisation is a concern and for this reason angiographic facility having CT capacity is essential to test every vessel before embolisation. Short and midterm outcomes are promising with substantial relief of symptoms and improvements in quality of life. Sexual function is unchanged or improved and there are few complications. PAE may be especially helpful in managing catheter dependent patients and those with giant prostates.

Centres trained to perform the procedure have been set up in Brisbane, Sydney and Melbourne and will emerge in other centres. Canberra Imaging Group has recently upgraded their Angiography and Interventional Suite to the latest available and is ready for this intervention. Urologist participation in management of patients suitable for this technique is essential in patient selection, urodynamic assessment and exclusion of prostate cancer. It is planned that patients treated in Canberra will join a database of Australian cases to assess its long term efficacy and its place in the algorithm of management of BPH.



Good general practice...*continued*

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Health Care Homes

With the trial of 'Health Care Homes' underway it's highly likely to lead to full-scale introduction. The Health Care Holes policy comes from the United States, a country with a poorly developed primary care infrastructure, and so the policy has led to some significant improvements.

Whether those improvements are replicated in Australia very much remains to be seen. As we already have good quality primary care in this country, the improvement is likely to be marginal, especially given the dismal funding available.

The UK's QOF

While GPs in Australia are not yet being forced to measure intermediary patient outcomes, GPs in the UK are. They are paid for their performance based on indicators in the Quality and Outcomes Framework (QOF). Numerous poor quality studies have shown an improvement in intermediary outcomes with the QOF and give the QOF credit.

Better quality studies show that performance was improving for a couple of years prior to the introduction of the QOF and continued at the same rate after introduction, so factors unrelated to the QOF are more likely to be the cause.

A more recent study showed that overall mortality has not changed in the UK since the introduction of the QOF.

Australia has an unfortunate habit of introducing international health policy without thoroughly analyzing its value and whether, given the system differences between countries, it's worth introducing at all.

Hopefully a QOF equivalent won't be introduced here.

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