Canberra DOCTOR

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AMA Family Doctor Week 2014

YOUR FAMILY DOCTOR:
KEEPING YOU HEALTHY

Celebrating general practice and our general practitioners

Capital Conversations with President, Dr Elizabeth Gallagher

As you will quickly see from the cover of this edition, it's our annual celebration of general practice and our colleague GPs who provide the frontline of community-based medical care.

As an O&G specialist, I have still more to learn about general practice, but I do know from my discussions with GPs over recent weeks, that they care passionately about their patients and the system we all work in.

The value of quality general practice should NEVER be underestimated. We know that a good relationship with a GP improves health outcomes in patients through primary prevention, through secondary prevention in patients with chronic health issues, and keeps patients out of hospital by dealing with problems at an early stage.

While the budget issues around general practice are still playing out; we can only implore the Abbott government to pay close attention and heed the AMA's opinions on these issues.. GPs are highly trained professionals and well respected by the community who look to them for advice and appropriate and timely treatment. GPs should not be responsible for collecting a tax for the government. GPs should not be penalised for choosing to bulk bill a patient in need, or who is financially disadvantaged. We have already stated that the AMA is not against a co-payment per se – but in its current form, the government proposed copayment is unacceptable and poorly thought out, disadvantaging our most vulnerable community members and also disadvantaging their GPs should they choose to forgo collecting the copayment.

Already we know that patients are nervous about this cost and even though it will not commence until July 2015, some GPs are already reporting that some of their patients are choosing not to make appointments. Potentially this means that patients are not seeking advice and receiving the right care administered in a timely fashion. There is concern that more patients may choose not to fill a prescription or have their pathology and radiology investigations, which may potentially lead to to poorer health outcomes and the need for more expensive treatments in the longer term. I have read that pharmacists are concerned that the $7 co-payment may mean an increase in presentations in pharmacies for health advice which should be given by the GP, yet another undesired outcome.

The recent budget also signalled the end of Medicare Locals. The tendering process for the new Primary Health Networks is going to begin later this year. The finer details are still to be worked out. We will have a better understanding of the whole proposal once the tender documents are released. The AMA's position is that these PHN's should be GP led and focussed.

Training GPs is a lengthy process and the training program means we are turning out quality GPs who can work in the community with safety and with confidence. General practitioners view the whole patient over the longer term – not just as a collection of body parts – and whilst we appreciate the skills of our allied health professional colleagues, we believe that handing over care on an ad hoc basis to a nurse practitioner in a walk in centre undermines the benefits of continuity of care.

We know that continuity of care is important to patient wellbeing and the concept of a medical home is being discussed by practitioners and planners alike. We know, too, that episodic care does not serve the patient's long term health care needs. I understand the need for governments to provide timely and affordable access to medical services, both in the acute setting and in the general practice, but we also need to balance costs against quality service provision. Affordable care does not necessarily mean the cheapest care, and the associated compromises that "cheap" may bring may not be so cheap in the long run if quality is compromised and the outcome poorer.

We have much to celebrate in the ACT and we should be celebrating our GPs and endeavouring to promote general practice as a viable and satisfying career option. We should celebrate our home grown services too; such as CALMS, and its huge contribution to the Canberra community over many years. Dr Ian Brown has written a column highlighting the successes and benefits of having good quality out of hours access to experienced GPs. Our ACT Medicare Local in association with CALMS has provided funding for the GP Aged Care Day Service, thus filling a large unmet gap in daytime GP service provision to nursing home patients and the frail elderly at home.

GPs appear to have been left out of the services delivery plan for our new University of Canberra Hospital. Surely this is an oversight as GPs are ideally placed to both advise on and deliver patient care in any multidisciplinary team in a new subacute facility which will have rehabilitation as one of its foci.

The ACT Government recently held an ED roundtable looking at ways of reducing waiting times and changing the utilisation profile in ED. The recent COAG report showed that the ACT is still doing poorly (even compared to other states) at meeting its waiting time targets. We are keeping a close eye on that space – as it is important that decisions are made with the involvement of ALL stakeholders and providers, especially GPs who may prevent the presentations in the first instance, and not just internally within the government agencies. It is also important that the REAL reasons for delays are addressed and changes are not implemented on preconceived agendas.

Whatever we do, let's not throw the baby out with the bathwater in a desire to meet other demands and challenges but rather let's build on what is good in strong partnerships between all the local players – government, bureaucracy, the ML, the AMA ACT and the medical profession.

GPs rule in Family Doctor Week

AMA Family Doctor Week 2014 is a time to acknowledge the hard work and dedication of the more than 30,000 GPs across Australia who provide high quality primary health care and advice to their patients in local communities in cities, suburbs, rural centres, country towns, and remote areas across the country.

The Family Doctor Week theme this year is ***Your Family Doctor – Keeping You Healthy***, which encapsulates the key role that family doctors play in all our lives, throughout all stages of life.

Family doctors work closely with their patients to identify and treat health problems early, better manage existing conditions, minimise the risks of disease, and provide advice and guidance to live a healthier life.

Nearly 90 per cent of Australians have a regular GP, and enjoy better health because of that ongoing and trusted relationship.

The personalised care and preventive health advice provided by GPs about exercise, diet, and leading a healthy lifestyle keep people out of hospitals and keep health costs down.

General practice is the cornerstone of primary health care and the most cost-effective part of the health system.

Family doctors are leaders in preventive health care, early diagnosis and treatment, coordinated care, and chronic disease management.

But they need to be supported in their important work.

The new Government came to office with a commitment to support general practice, and that commitment was on show in the first few months of the Coalition being in power.

But everybody was shocked when the Federal Budget in May unleashed a torrent of attacks on general practice.

There had been warning signs just weeks earlier when the Government released the Commission of Audit report, and certain commentators had been promoting GP co-payments since before Christmas 2013 – but nobody expected the massive cuts and changes to primary care in the Budget.

There was the $7 co-payment for GP services.

There were new co-payments for pathology and radiology.

There was permission for states to charge co-payments for emergency departments.

There were higher co-payments for medicines.

There was the $5 cut to Medicare patient rebates.

And MBS patient rebates for specialist services were frozen.

On top of this, there were cuts to Indigenous health services.

The Government is also reducing public hospital funding by $1.8 billion over the next four years, and reneging on the guarantee of $16.4 billion additional funding under the National Health Reform Agreement over the next five years.

All of these acts will have a devastating negative effect on primary care. They will hurt GPs and their patients.

There is some light, however.

When I met recently with Prime Minister Tony Abbott, I believe he saw the wisdom of the AMA's ways in opposing the GP co-payment and other measures as proposed by the Government.

The PM's political antennae could detect the harm to vulnerable people in the community, especially the elderly, the disadvantaged, the chronically ill, and Indigenous Australians.

Within 48 hours, the Government publicly acknowledged they should revisit the co-payment for people in aged care.

The Prime Minister has asked us to come back to the Government with some other changes – changes that could possibly make some of the Budget reforms palatable to the AMA and the community.

There are no guarantees, but it is a start.

In the meantime, Family Doctor Week puts the focus on general practice and reminds people about the importance of family doctors in local communities.

Family Doctor Week allows the AMA to highlight all that is good about general practice and family doctors, and it also allows us to discuss issues or policies that need to be resolved to allow general practice to provide even better services to Australian communities.

Above all, Family Doctor Week is a chance for the medical profession to remind people about the importance of looking after their health.

Throughout Family Doctor Week 2014, the AMA will be issuing media releases and videos to inform people about important preventive health measures they can and should undertake with their family doctor.

The AMA will also be raising health policy concerns that could negatively affect general practice and make it harder for family doctors to continue providing high quality, affordable and easily accessible comprehensive health care.

Assoc Professor Brian Owler is President of the Australian Medical Association

The AMA Family Doctor Week website is at https://ama.com.au/familydoctorweek2014

The AMA has produced videos to promote Family Doctor Week 2014:

Family Doctors provide targeted health care for patients at all stages of life with expertise, understanding, and distinction

https://www.youtube.com/watch?v=y-n2mEfFdlg

The wide range of preventative care administered by family doctors ensures quality of life for patients and a sustainable heath system https://www.youtube.com/watch?v=_i4c0-lFHdc

General practitioners can help people reduce their risk of illness and disease, such as diabetes, heart attack, obesity, and depression https://www.youtube.com/watch?v=J79_1LdJApA

A/Prof Frank Jones elected President of the RACGP

Western Australian GP, Adjunct Associate Professor Frank Jones is the new President-elect of the Royal Australian College of General Practitioners (RACGP) and has vowed to place general practice at the heart of public dialogue.

Following a 4-week election period, A/Prof Jones will take over the prestigious role from current RACGP President, Dr Liz Marles, whose 2-year term comes to an end in October.

A/Prof Jones is a staunch advocate for general practice and is committed to raising the profile of GPs' role within the Australian healthcare system.

RACGP President-elect, A/Prof Jones said one of his first priorities is to continue the RACGP's efforts to address the profession and public's concerns surrounding the proposed $7 co-payment for general practice services outlined in the recent Federal budget.

"It is now a month since the Federal Budget was announced and anxiety over rising out-of-pocket healthcare costs and the removal of a universal healthcare system continues to increase.

"The general practice community looks to the RACGP for leadership on this issue and we have a responsibility to represent the concerns of our members and the profession at large.

"I am determined to continue the RACGP's advocacy on this issue and to lobby for an amended and enhanced arrangement that does not force GPs to absorb the cost of vulnerable patients and that protects Australian patients who already face numerous barriers to accessing healthcare," said A/Prof Jones.

A/Prof Jones has over 30 year's clinical experience in rural and regional general practice and is committed to ensuring a sustainable and well-resourced general practice profession through strong leadership.

"The profession is in the midst of very uncertain times and strong leadership, reflective of member opinion, is now more critical than ever. Stakeholders should recognise the RACGP as a vibrant solution based organisation.

"We must safeguard the role of GPs, as the clinical gatekeepers to a quality healthcare system," said A/Prof Jones.

General practice – it's all in the family

As we approach Family Doctor week, I am taking the opportunity this year to really think about what that means to me.

The Doctors Res family.

I come from a family of doctors, with my father being the epitome of the gold medal scholar at University, and the physician to Royalty in Malaysia.

My parents moved to Australia when I was 4 and my early memories growing up were always involving the work my Mum and Dad did – my mum as a solo GP for many years, and my Dad as a General Physician.

My sister and I would spend many afternoons after school in my Mum's practice, helping her with the filing, getting to know her patients, and of course, doing our homework!

During school holidays, we would spend a lot of time with my Aunt and Uncle, also GPs, and my family has helped to shape my work ethic and commitment to practising medicine. As they all approach their 70's, they are all still working and contributing meaningfully to their community.

I met my husband on the very first day of our medical student journey at the University of NSW and we have been happily together as a team for nearly 22 years. We have made Canberra our home since arriving here as interns at the Canberra Hospital in 1998.

Over the years I have enjoyed my work in some different areas of medicine, including Psychiatry, Medical Officer at the TGA – which certainly allowed for a greater understanding of the regulation of pharmaceuticals, and of course, general practice.

Why did I finally decide on becoming a GP? I think general practice allows for amazing flexibility and certainly in Canberra, many of us are lucky enough to be able to experience a number of different work options during the week.

So many of my colleagues teach, do research, academia, administration work, Defence work, forensic medicine, prison medicine, as well as clinical general practice.

I have been lucky enough to have had the opportunity to teach and mentor junior doctors at the Canberra Hospital, during their rotations in general practice, and have admired and been inspired by their enthusiasm and energy to learn and embrace all that the experienced GPs at their practices have to offer them. A number of these JMOs have gone on to join us in GP land, and certainly all have come away with a greater understanding of the complexities and challenges that make general practice so unique.

Over the last few years, and probably since becoming a mum myself, I have seen my general practice evolving into more of a women's health and preventative medicine focus. Working mums trying to sanely juggle kids, home, partners, work, and their own health and well being is always a challenge, and I see this amongst my patients, my colleagues, friends, and myself!

As I talk with my patients about the morning rush and routine, school drop-offs, lunch boxes and pick ups, before and after school care and activities, busy hours at work, preparing dinner, night routines, having some sort of meaningful conversation with your better half before falling asleep on the lounge.... I'm struck by just how "busy" everyone's lives seem to be.

Does it have to be this way? Sometimes we get so consumed by the pace of life that we forget to experience the moments that make it rich and worthwhile.

Life sometimes throws the proverbial 'curve ball' at us which may mean we have to "stop and smell the roses".... And let me say, those roses are amazing.

During these school holidays, I've spent a lot of time with my soon to be 4 year old daughter and loved every minute of crafting, playing, reading, cuddling and being fairies together. It has served as a good reminder of why I do what I do. I want to be a good role model for her, just as I have had growing up, and as I do now, surrounded by the most inspiring female and male doctors and friends. I want to do that with balance and with care to show that life is about sharing your knowledge and creativity with your community, and growing together in a healthy and happy way.

This is difficult to do if long hours are spent in the office away from your family. You and your family's health and well being are paramount to you doing the best you can for everyone else.

How you achieve your inner balance is your own personal journey, and will be different for all of us. All I'll say, is do make the time for that, and perhaps that is the one message that I will be leaving you with during this Family Doctor week.

Look after yourself and your family, give yourself the same courtesy and care you so generously give your patients every day.

Enjoy work, enjoy life and most of all celebrate your family and friends.

Sonia Res is a Canberra GP with special interests in teaching and research at the Academic Unit of General Practice and ACT Health, ANUMS and ACT Health, and women's health and preventative medicine in clinical practice.

A call to arms for General Practice

I am passionate about general practice and its value to the health care system. I believe that high quality generalist medical knowledge coupled with a long term relationship with a patient and sound understanding of their family and community provides the best opportunity for making significant improvement in individual, and the community's health.

However I have spent too much of the last 2 months feeling disheartened about the multiple challenges for general practice in the latest Federal budget which, in my view, reflects poor understanding regarding the value of general practice in the health care system.

General practice is the backbone of the Australian health care system but it is too often dismissed as being in some ways of lesser value by the health policy makers, some of the public, and even at times by our specialist colleagues.

A perfect example of the threat is the proposed introduction of a $7 co-payment for GP services from July 2015 which is seen by many as an end to Australia's commitment to universal health care. This has been one of the most contentious of the budget announcements but there is still great lack of clarity about how this is likely to be implemented and administered.

GPs and GP organisations have significant concerns regarding the effect of these changes given the good international evidence that they will adversely affect access to health care and will have detrimental effects on the health of the chronically sick and socio-economically disadvantaged particularly.

ACT GPs will also be in the invidious position of having to choose one of the following options

a. to continue to bulk bill 55% of their consults and take a significant drop in income (ie if they don't charge they will get the reduced rebate and no incentive payment for the first 10 consults per year for each patient)
b. to charge a $7 co-payment, incur the wrath of patients, knowing their actions will have a negative effect on the health of some of their patients and have no change in income compared to current situation.
c. Charge a co-payment that is >$7 which for approximately 45% of consults will be business as usual but for the others would make their services unaffordable and in all cases would leave the patient $5 worse off.

Currently in the ACT the 55% bulk billing rate is significantly lower than the National average of 85% so, while on the one hand GPs incomes may be less significantly affected than those areas where 95% of consultations are bulk billed; on the other hand – those people who are currently bulk billed are probably those that GPs feel really need to be bulk billed so shifting their practice may be more challenging

The quantum effect on demand is also unknown – if the people who currently make up the 45% of bulk billed consultations reduce the frequency of their visits by 25% then there will be a significant change in presentations. In the short term at least this may decrease GP incomes. In the longer term (as the ACT still has a significantly lower than average FWE compared to the rest of the nation and lower number of annual visits to GP per year) this may provide improved access for those people who can afford to pay for care but increase the disparity of care between those of lower and higher socio-economic background.

Amongst the GP media it is also evident that the singling out of GP rebates for co-payment and the defunding of preventative health initiatives is a sore point for GP morale. The bulk of health care costs occur in hospitals and the majority of out of pocket payments for medical care are charged by specialists not GPs. The differential between GP and Specialist incomes is already significantly greater in Australia than in almost all other OECD countries. No doubt the government's rationale is that the GPs are the gate keepers to the rest of the system. However, GPs feel their contributions are relatively undervalued and this budget has reinforced that sense whilst leaving specialists unscathed.

As a profession our great diversity is part of our great strength but when it comes to politically lobbying it is no doubt one of our greatest weaknesses. Somehow we have to find a way to accept the great variation in practice size, structure and individual clinical approach but unite around a common message of the value of high quality primary care. The co-payments' issue is just one of the threats, the others include changes to GP training, disinvestment in prevocational general practice placement program and the deregulation of University education which will drive up the cost of a medical degree and drive down the percentage of our graduate who choose general practice.

Kurt Stange an eminent American primary care doctor has talked of "the added value of integrating, prioritizing, contextualising and personalising health care across acute and chronic illness, psycho-social issues and mental health, disease prevention and optimisation of health and meaning". The vast majority of great GPs in this town add this value to the ACT health care system every day they practice. Now our great challenge is to get better at measuring that value and shout about it from the rooftops.

Kirsty Douglas
GP Winnunga Nimmityjah
Professor of General Practice ANU

Variety: the spice of life

Monday morning: the start of a new week. As in every practice Monday is busy. What will the day bring I wonder as I look at my appointment book. The weekend has allowed our patients to brew all kinds of maladies, some acute and others a progression of their chronic ailments.

All however need to be seen ASAP, so the phones at reception run hot.

I am fortunate enough to be able to wear two hats, and this is the beauty of being a general practitioner. Not only can I be a family doctor, but I am then able to put on my other hat, my "Special Interest" hat, and take on a different role. Many GPs have a special interest which can add to the fullness of their practice. Some integrate this special interest within their day, others dedicate entire sessions.

In my case, my Special Interest is in Sleep, and I have been able to practice this at the Canberra Sleep Clinic alongside skilled and experienced staff. My sessions at the Sleep Clinic are pleasant and predictable. As poor sleep is the issue for all the patients, there are few surprises, (unlike a typical day in general practice), so the day progresses and I keep to time.

My interest in sleep started as a result of having a young son with sleep apnea. As a mother I had concerns for some time, but the literature and evidence base for the diagnosis and management of sleep apnea in the paediatric population was unavailable. Two years after being advised that he was "fine", the literature published suggested otherwise, so we started down the treatment pathway and I am glad to say that he has improved. Interest in sleep and its effects on our well being and performance continued to grow from there.

Back in general practice, I look to ensure that a good sleep history is taken from my patients and that I pay particular attention to those concerned mothers. I have learnt that the evidence is not always readily available or necessarily current.

However, unlike our specialist colleagues who are experts in their chosen fields, general practitioners need to be able to manage a myriad of different ailments, affecting multiple systems (some of which are hidden even to the patient themselves), whilst keeping in mind the whole person.

Each patient who enters is a new mystery to be unravelled, and this is what excites.

Of course there are the usual requests for scripts, the worried but otherwise well who need reassuring, and the lonely and forgotten elderly, who come to see their family doctor more for a chat, and a way to connect with another, although... these are often Tuesday patients.

I am interrupted by a call from reception. Can I fit someone in? No fit ins for our specialist colleagues.

My ability to keep to time is far less predictable and the surprises that enter through the door at times create mayhem. Ahh yes!! It's Monday..... But that is what adds the spice that creates the fabric of life.

Gerry Miller is a Canberra GP with a special interest in sleep medicine.

What's in a title? – quite a lot!

I have been asked to write an article describing my job as GP Advisor to ACT Health, a job that involves reviewing policy documents and sitting in meetings.

Hmmm, maybe I need to find a way to make the job sound more interesting!

I try to influence the policy of the ACT government when it is about or relates to General Practice. It is an interesting and varied role, where I advocate within ACT Health for GPs and support ACT Health in its interactions with GPs.

My position is one of a number of GP roles within the ACT government aiming to improve interactions between the ACT government and primary care. The others are the GP Liaison Units, which focus on the hospitals and the communication between GPs and hospital based clinicians such as improving discharge summary quality, and the Academic Unit of General Practice, which focuses on education and research. I concentrate on policy and issues that cross over multiple campuses, of the hospitals and community health centres. The Medicare Local also works in this space, but I will leave them to describe their role.

Policy is a challenging area as most health policy is developed by politicians, public servants and sometimes clinicians, but almost always by non-GPs. There is often a misunderstanding of general practice, our strengths, what we can deliver and the challenges. Health policy can have direct or indirect impact on GPs and it's my job to influence these policies and decisions so that the general practice perspective is heard. I also try to educate ACT Health staff to ensure government resources aren't used providing services which are easily delivered in the community by GPs and can be spent on something that requires the public system.

If this sounds a bit hard to pin down, then I might be describing it well. Maybe a couple of examples will help. I have been supporting smoking policy. You may have heard that ACT Health is going smoke free in September. This means no smoking will be allowed on any ACT Health premises including the Canberra Hospital. There is a change management project going on to ensure there is support for staff, patients and visitors who smoke. Early versions of the smoke-free policies did not discuss GPs and our role in managing smoking cessa-

tion. This is an area where it is easy for GPs to support the ACT health policy as smoking cessation is something we already do well and more frequently than hospital clinicians. So, I ensured that referral to GPs was included in policies and in supporting documents such as brochures and information sheets for patients.

The Walk-in-Centre has recently moved from the Canberra Hospital site to Belconnen and Tuggeranong Health Centres. The WiC is loved by the community but is controversial in general practice circles. My role as an advisor was to do whatever was needed to support the move such as reviewing policies, educating staff and signing off on clinical competencies.

There isn't a great understanding of systems and service availability going both ways – from the hospital to general practice and general practice back to hospital. GPs often see ACT Health as a homogenous organisation and it can be hard to distinguish the efficient departments, with quick review of referrals and short waiting periods, from those without. I sometimes feel sorry for departments that have made an effort to improve their systems and services but whose effort isn't noticed by GPs.

Conversely, ACT Health staff rarely have a feel for the diversity of services delivered by and conditions managed in general practice. Along with the patients, it is this diversity that makes general practice interesting. Anyway, a condition common in a specialty area can be quite rare in general practice. GPs receive a lot of resources from specialty areas on specific topics, invariably in hard copy although most GPs use electronic medical records. Some of the resources are more useful than others and even the good ones can be hard to find when a GP finally has a patient with the condition months down the track. I provide advice that succinct information available electronically is best.

I find the most interesting aspect is thinking strategically about how ACT Health is interacting with GPs and how this could be done more efficiently. Some areas want GPs to have a greater role in managing their patients and others keep patients beyond the clinical need to do so. Often there is a mismatch between the ACT Health staff actions and GPs' ability to manage the relevant condition. For some conditions I am working on shared care guidelines to support the transfer of care from tertiary back to primary care and for other conditions such as smoking, it's simply a matter of letting GPs know about the policy change. Mostly this area is still a work in progress and there is plenty of work to keep me going for a long time.

Marianne Bookallil is GP Advisor to ACT Health and a GP at Winnunga Nimmityjah Aboriginal Health Service.

Change to career aspirations

Ten years ago the ANU Medical School welcomed its first students. As we celebrate Family Doctor Week, I have been asked to write from the perspective of one of those first students who has ended up in "GP Land".

I see the ten year anniversary of the medical school as a celebration – we celebrate the graduates who have taken the path to general practice, but we also celebrate those that are working through their specialist training, as those of us in general practice need their expertise.

As a new academic for the ANU Medical School's Rural Clinical School earlier this year, I sat in a lecture theatre with the new long term rural students. In mid-sentence, the absurdity of the experience struck me – I was surrounded by three professors, who had been so when I was a student at the Medical School seven years ago. Next to me, cracking jokes, was my medical educator for my general practice training. And now I was joining their ranks.

It caused me to reflect on my last ten years – from those student days; through my internship and residency at Wagga Wagga; to my general practice training; to now being a GP with VMO rights.

I feel somewhat of a fraud writing for Canberra Doctor, as I do not live or work in Canberra. I live in Cooma, and work in both Cooma and Bombala in Southern NSW. As a young(er) medical student, in 2004, I had come fresh from an honours year in virology. I thought, when I grow up, that I might like to pursue a career in Infectious Diseases, or maybe Emergency Medicine (probably due to too many episodes of ER). It was not until my placement in third year of medical school that I was really introduced to rural general practice; and thought, actually, this rural GP gig is not so bad – here is where you get to do it all – infectious diseases one day, emergency medicine the next. What a formative time.

Through my training I discovered that medicine was less ER, and more Scrubs. That sometimes you didn't always know what to give "stat", and that some days you feel like hiding in a broom cupboard. But general practice is the challenge that I love to face every day.

I wear several hats. During my GP time I do the usual – manage diabetes, the obligatory "tears and smears", the general practice follow ups. I supervise medical students and the junior doctors through the PGPPP.

Today, as I write this, I am an Emergency Department doctor. A trauma patient could be wheeled through the door. Fractures, AMI's, strokes. An ascitic paracentesis here, an arterial line there. A mixed book of everyone sick (and not so sick) with a healthy dose of procedural medicine.

As a lecturer for the ANU, I give weekly tutorials, and enjoy trying to encourage the next generation of students to love rural medicine as much as I do.

As the Vice President of the NSW Rural Doctors' Association, I might be meeting with NSW Health, or putting out political fires; attending meetings or giving media interviews.

The great thing about general practice is that I continue to learn. Every day. From colleagues, from specialists. And perhaps most importantly, from patients. What a privilege that is.

Emma Cunningham is a GP VMO in Cooma and Bombala

Musings on a journey

When I turned six years old I was a patient on a passenger liner called the "Northern Star" sailing to Southampton (my Dad was going to train as an ophthalmologist in London).

Caroline with her father.

Myself, two younger sisters and multiple other young Australian and New Zealand kids had caught the measles – likely during our visit to Tahiti. It was a fun week because my father was the ship's doctor and he would visit us twice a day. I selfishly thought it was because he wanted to see his own children but, of course, later I discovered there were some children who were seriously ill from the spotty affliction. When Dad would leave the ward, I would pretend I was the doctor doing rounds (with my sisters in tow as nurses) and proceeded to poke and prod children who were likely too ill to protest or gave into my indulgences because I had shared my birthday cake with them only a few days before. Such was the start of my desire to be a doctor.

As time went by, the expectation that I would study medicine became greater and so, in spite of thinking about becoming an architect or chemistry and Latin teacher, I ended up graduating with MBBS from Sydney University and well on the road to a clinical career. And now in this Family Doctor Week 2014, I reflect on what has been a wonderful journey over the last 30-odd years.

After ditching a 2-year stint in anaesthetics, I chose General Practice because of its diversity and flexibility and to get away from the hospital environment. Bulk-billing was just an idea and an over-governanced profession and the rise of the specialists were still a long way off. In my early career as a GP in Sydney, patients were not as worldly or as well-educated and expectations were not so high. It was usually one problem-one consult and, after handwriting the notes, there was time for reflection and discussion prior to the arrival of the next patient. Specialist referrals were the exception, not the rule, and the local GP had the opportunity to perform obstetrics, surgery, and anaesthetics. However, I could see that I need to add some strings to my bow.

I chose to spend some time working for the military and this contract medical officer work lasted for over 20 years both in Sydney and Canberra where I became well-versed in the health requirements of military personnel and the administrative skills for Defence health policies.

Today, as with many of my colleagues, I have semi-specialised in the realm of sports and occupational medicine. It's not that there are a whole lot of new illnesses but we're living in vastly different times and I believe that the patients or, at least their expectations, have changed. The GP is now just another provider of services and frequently perceived as no different to a plumber or a mechanic. Happy to miss or cancel appointments, these same people complain when they have to wait for more than ten minutes. Through the Internet and Google Gen X, Y and the iPod generation are now instant experts on their own health and love to self-diagnose. Antibiotics or anti-depressants are the cure for everything and, if not satisfied with the outcome of an appointment, they will doctor-shop until someone else tells them what they want to hear. Thank goodness for the baby boomers who still understand manners and appreciate our efforts.

So how have I got around this change? For the past decade it has been a privilege to prepare the next generation of doctor by teaching clinical skills to Years 1 and 2 students at the ANU medical school. More recently I have been appointed a pre-vocational medical education officer at TCH ensuing quality supervision and pastoral care for the JMOs undertaking their surgical rotation. In many of my students and junior doctors, I can see the same aspirations and hopes that I had at their age, and it is an honour to see them develop as a professional. But there are also differences with these newbies: for many it will be but one in a number of different careers; for some a means to make ends meet; and, hopefully for others a true vocation. So where to? I see my career as a GP with face-to-face patient time diminishing as I plan my retirement with my totally awesome husband. However, teaching students and mentoring young doctors will still remain a passion as I share my knowledge and experience.

Caroline Luke is a Canberra GP and has many other roles

Double your points

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Winnunga Aboriginal Health Service's approach to holistic medicine

The ethos of Winnunga as with all Aboriginal health services around Australia is to provide comprehensive, best practice care that is accessible to all clients with a holistic approach based in a multi-disciplinary setting.

The National Aboriginal Health service working party (1989) defined health as "not just the physical well-being of the individual, but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life–death–life."

This very much resonates with the concept of practising ***holistic medicine*** in treating the complete person, physically, psychologically, socially, and spiritually, in the management and prevention of disease. It is underpinned by the concept that there is a link between our physical health and our more general 'well-being'. In a holistic approach to medicine, there is the belief that our well-being relies not just on what is going on in our body physically in terms of illness or disease, but also on the close inter-relation of this with our psychological, emotional, social, spiritual and environmental state. These different states can be equally important. They should be managed together so that a person is treated as a whole. In fact some feel that the word holistic should really be spelt 'wholistic'.

Julie Tongs OAM, CEO and Nadeem Siddiqui.

Winnunga strives to provide such services that reflect a holistic approach to medicine by having a multidisciplinary team of clinicians, nurses, Aboriginal health workers, mental health team, access workers and lastly but by no means least Aboriginal staff who make up the social and emotional wellbeing team all within its four walls.

An example where Winnunga provides a holistic approach, is with its open access system for most of its services including general practice. Clients are not required to make appointments. They simply turn up when seeking health care without the perceived barriers in having to make appointments or attending at a scheduled time. The decision to do this was based on client preference. It suited the needs of the community in which there are significant amounts of social stresses, drug and alcohol problems and mental health issues along with chronic illness and physical ailments.

This does of course pose service challenges in catering to client needs. There is not a day at Winnunga which isn't uneventful! Staff have to adapt to the peaks and troughs in client numbers on the day as well as manage the challenging complexities that most often have to be dealt with on the same day too.

It is not to say one system is superior to another but an example where health care delivery has adapted to the needs of the client and community to provide a holistic approach, the hallmark and rationale behind establishing an Aboriginal community controlled health service.

Another example at Winnunga, adapting to a holistic approach, is addressing the cultural, emotional and spiritual needs of the clients. The intergenerational trauma experience by Aboriginal people should not be underestimated in terms of its impact on physical, mental and social determinants. Part of Winnunga's vision is to break this cycle: traumatised parents invariably pass this on to their children who then grow up to be traumatised themselves. The trauma not only brings about mental health problems, compounded by social disadvantage, leading to, in a lot of cases, drug and alcohol problems and the consequent sequelae of physical illness. Our staff are trained to have a heightened awareness of such issues surrounding an ill health episode and to address those multiple factors through a multidisciplinary approach.

It means for the service that consultation times cannot be scheduled rigidly and have to be fluid in order to accommodate and address the multiple issues surrounding a client's health. It starts with health care staff empowering the patient to value himself or herself by allowing to and listening to their ideas, concerns, and expectations. A basic but fundamental consultation tool that provides core ingredients to a successful consultation and the potential to achieve good health outcomes through engaging the patient.

These are some of the thoughts and workings at Winnunga striving to deliver holistic services. This I believe is Winnunga's focus and uniqueness as a health service but at the same time its challenge to continue to provide this effectively in an ever changing political health care environment.

Nadeem Siddiqui
Executive Director of Clinical Services, Principal Supervisor Winnunga Nimmityjah Aboriginal Health service

When is Enough Enough?!

Not knowing when enough is enough has always got me into trouble.

As a 23 year old intern my father shouted at me not to pursue "just one more waterfall" at a family weekend in Edith Falls south of Darwin. "you never know when enough is enough Michelle!" Clearly he saw me drifting off into the bush in a 'Picnic at Hanging Rock' like haze, accompanied by my unsuspecting Scottish boyfriend (now husband). Clearly, I was at risk of crocodile attack or worse. Or maybe he just wanted to get on the road. The point was I wanted to see the waterfall beyond, I thought just a bit more hiking, in the searing heat, would reveal utopia. Just try harder.

I'm pretty sure every reader of this paper spends their lives trying harder, but when is enough enough? When do we "settle" for what we have achieved? How much striving is actually beneficial for our families and our patients and how much is infuriating them? Commonly my 15 year old boy is exasperated by my questioning. He too shouts at me: "Mum! Enough!"

Last night I was called to the scene of a gentleman who had collapsed at the adjacent table in a restaurant. It was all pretty easy and he came to quickly. However he was furious with me for calling an ambulance. He refused to go despite acute changes on the ECG and his wife's pleading cries.

I tried to talk him round but eventually said "of course it is your decision". He very indignantly and sarcastically exclaimed "thank you for giving me a choice about my own health!"

Perhaps I had gone too far in calling the ambulance when he had regained consciousness, perhaps I was being selfish in my pursuit of caring for this stranger. After all, I wanted to look good in front of my family, I couldnt have him just lolling about being clammy when super doc was here! But perhaps enough was enough for him and I should have left him alone. Most doctors want to just collapse of a heart attack and die at some suitable age, as I got the impression he was trying to tell me.

My 18 year old was quite dismayed at the poor reflection of "the system". The repeat of the required $800 ambulance fee and his percieved wasted time in the ED, the whole episode was a repeat of events from the previous week. Of course, I suspect his arrhythmia was not evident then, and he had not developed ischemic changes.

Sometimes, I am involved in mentoring GP registrars. Their biggest challenge is coping with the world without endless investigations, consults and time in a hospital bed. They feel paralysed by having to cut off the never ending possibilities and go with the most common, most easily and in-expensively delivered investigations (if any) and move on with a treatment plan. They too need to hone their "enough" skills.

But … What about all those times I did keep asking, about that unexplained fever, that elevated ESR, that pallor?

When have we done enough?

Michelle Barrett is a Canberra GP and principal at the Hughes Family Practice, Medical educator CCCT and senior staff specialist, Canberra Hospital

The challenge of communication in patient care

The concept of the Family General Practice as the "medical home" for the patient is a good one.

Suzanne Davey at Machu Picchu.

However it requires not only a high standard of care to be provided to the individual patient and their family members. It also requires a high standard of communication between the general practitioner and other Health practitioners responsible for the care of the patient.

This high standard of communication begins within the general practice itself, where there should be adequate handover between fellow practitioners to ensure continuity of care when the patient is not able to see their own doctor, or when their doctor is on leave. This involves verbal communication between doctors and the keeping of very good contemporaneous medical records including the doctors' impression as to what is going on (rather than just findings on examination and diagnosis) in the case of a complicated patient, as well as a prospective management plan being continually updated.

The next level of good communication should be between the general practitioner and the specialist. This involves the GP writing a detailed letter of referral of the patient to the specialist, and the specialist writing an equally detailed letter in reply. In urgent cases this communication should also be verbal by telephone. This involves the specialist making him or herself available for telephone consultation, or returning calls when requested to do so. Equally, the GP should provide a mobile number so that the specialist is able to return calls directly. This also includes communication between the GP and the anaesthetist in a patient requiring surgery, and between the GP and the allied health provider and the pharmacist. The pharmacist should not question the prescription of a particular drug to a patient by a GP, to the patient directly, without consulting with the general practitioner who wrote the script.

Good communication is also paramount between the GP and the hospital doctor. Doctors in the Accident and Emergency Department should treat General Practitioners with the respect they deserve as the doctor who has assessed the patient regarding their current condition, but who also has the benefit of knowing the full past history of the patient. If a patient's general practitioner makes the call that a patient requires admission to hospital for further assessment, then that GP should not have to beg over the phone to request timely assessment of their patient, and the patient should not have to go to the end of the Accident and Emergency Department queue in order to be reassessed from the beginning by a doctor who probably has far less experience than the referring doctor.

The Patient Controlled Electronic health Record (PCeHR) was supposed to be a tool to facilitate communication between the patient's primary care doctor and other health care providers. However, in order for it to be an effective management tool, it requires the General Practitioner to continually update the electronic health record. No doctor is going to bother to do this time-consuming task unless they can see the value in doing so for their own benefit and for their patients' benefit. It goes without saying that the person responsible for the upkeep of the record should have the primary say in what goes into that record! From my point of view, the one thing that would make the record worthwhile is for it to have an up-to-date results feed from pathology providers and radiology providers, no matter which provider ordered the test. The pathologists and radiologists offered to provide this service without charge for the benefit of doctors and their patients, but the developers of the PCeHR declined their offer! Thus the entire electronic medical record concept remains in jeopardy, as a result of inadequate consultation and communication between the designers of the programme and general practitioners who are responsible for maintaining the currency of the record.

Hopefully, the coming year will see enhanced communication in all of the areas mentioned above, to facilitate better patient care for the individual, and a more rewarding working relationship between the Primary Care GP and the other health care providers involved in the care of the individual patient.

Suzanne Davey is a Canberra GP and a director of AMA (ACT) Limited. Dr Davey is the ACT representative to the AMA Council of General Practitioners

Reflections

I've finally reached the time of life when I have stopped running to keep apace with demands, and I've been able to stop, look around, look back, and reflect.

Thirty- two years ago I was presumptuous enough to set myself up as a GP, with 4 years in hospitals and several GP locums under my belt. It was the early days of the Family Medicine Programme, and I remember attending general practice training workshops with other young female graduates clutching their toddlers, wondering how we were going to get back into a valid training situation.

Having now exposed myself to the reality of general practice, I realized there were gaps in my training you could drive a truck through. So juggling home, family and practice, the search began for ways and means to up-skill. Fortunately it was the time of an emerging distance education system, and I entered the wonderful world of on line education. The first courses involved hard copy postage, with assignments and exams returned with red pen marks and comments reminiscent of school days. There were occasional weekend workshops where students and teachers actually met, and it was like being a kid at university again, and great fun, with exposure to some wonderful teachers and clinicians. As time went on the courses became more and more paperless, until we were getting streamed lectures and group telephone tutorials, with presentations to panels of examiners over the phones.

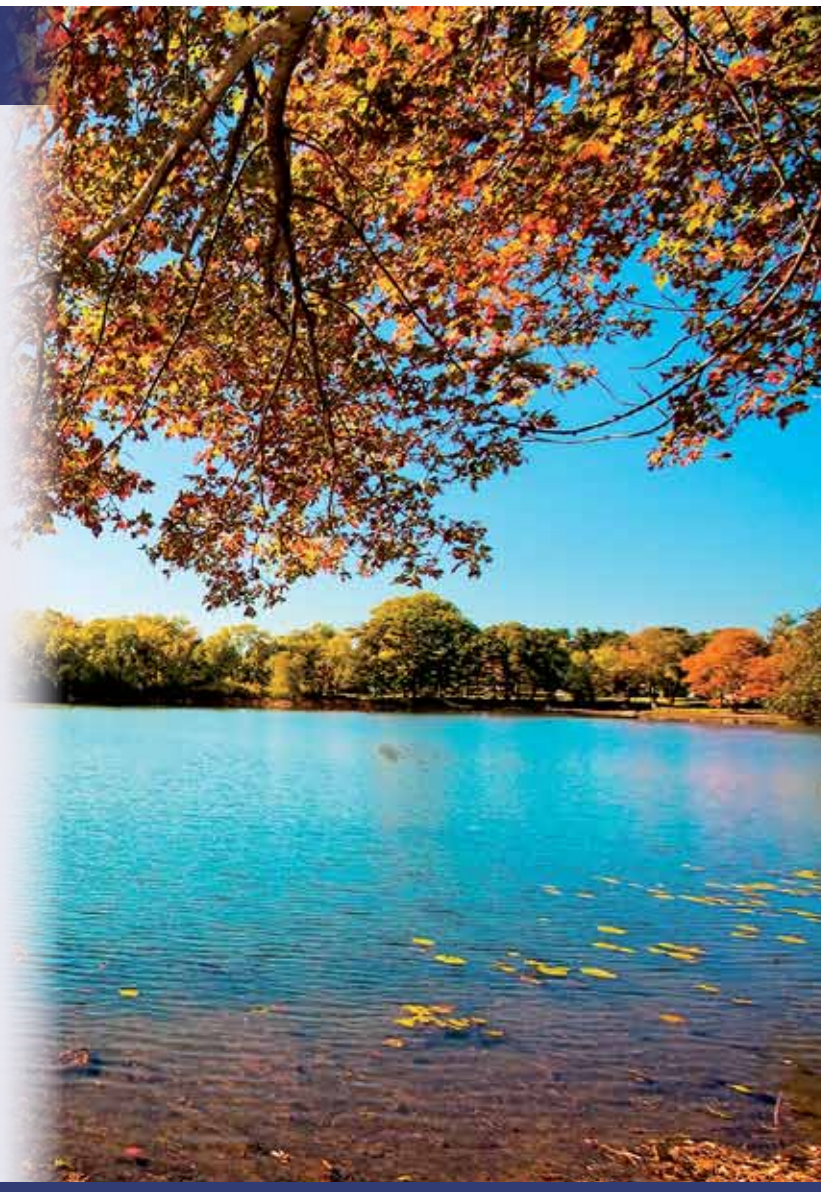
I was to spend a total of another 10 years in my virtual university, sometimes only doing one subject a semester. I seem to remember years without weekends, though the 3-month break at Christmas allowed a catch up. It seemed strange that I still had my day job to attend to at that time. Of course education costs a lot, and I don't believe it would have been viable if I had not been working in the industry and tax deducting expenses. Earnings do not increase simply by getting more qualifications in this business, and I am glad the tax deductibility of education continues.

The hunt for training and greater exposure to different aspects of medicine did not abate with time, and I found myself volunteering to do some work in ED at the Canberra Hospital. Having been away from hospital medicine for many years, I was poorly prepared for the pace and sophistication of such a busy department. It was fascinating to gain some insight into the workings of the hospital, which is as complex as a small city in itself. With time I gained some confidence in dealing with the less extreme emergency situations, and I believe it has helped me triage patients in general practice.

Still not content with an office job, I've recently volunteered to do some surgical assisting in our local hospital. Now I can track the experiences of patients after that surgical referral letter is written. In my resident days, I remember hauling back the rib cage of patients on the table, to give surgeons access to the gall bladder. Now we delicately hold the end of the camera while looking at the anatomy of the patient unfold on the screen beside us. I'm finding it fascinating to see all these conditions we diagnose in the flesh, so to speak.

So, what is next? Well, I'm very tempted now to look at the world outside, and see what else has changed in the last 30 years. It may be time to hit the road.

Jill Brown is a Canberra GP



Keeping you Healthy?

There's no better time to reflect on the nature of General Practice than during Family Doctor Week. I like the theme – enunciated above – but I've reached an age where I find myself automatically retracing one step. Before I can keep you healthy, I must perform the same task for myself. So get in line.

Now it should come as no surprise that I do this with the aid of a GP. But of course, I need to co-operate. Take the pills, get the tests, do the exercise. And if I do, I get reasonably healthy. And if I keep doing these things I'll likely and hopefully stay that way. In this, I'm no different from anyone else.

My point is – primary care is active. You can't give someone good primary care any more than you can give them good manners. It's something you have to want.

Tertiary care is totally passive. You lie in intensive care and people do things to you.

Anyway, I get myself healthy and then I can start on you. So to all my colleagues – do the same. Get yourself healthy and then you're able to assist others to do the same. There is no doubt in my mind that being a GP is one of the toughest jobs that exists. Many things contribute to this; among them the many and varied tasks, the constantly changing knowledge base and regulatory environment, the frequent need for concrete decisions and the almost universal absence of protected downtime during the working day.

A respected colleague once said to me "I'd enjoy General Practice more if I did a bit less of it ". Now that I myself do a bit less of it I find this is true. I've always enjoyed my work as a GP but now I positively look forward to Mondays and Saturday mornings [my time in general practice].

As GPs our job is to maximise the health of our patients. If they have no disease, we try to assist them to prevent it. If they have any disease, we try to assist them to minimise its impact on their lives. I'm fond of saying to patients that we have to make your disease live with you – not the other way round.

And that's modern general practice. We've moved on from episodic care and now find that chronic disease management forms the major part of our work. And important work it is. A patient with diabetes costs the health budget around $5500 per year. If complications arise, this rockets to about $15500 per year. Diabetes, like so many other things, can't be cured. But it can be managed. [I know this is in dispute]

I believe one of our big future challenges will be to move on from chronic disease management and take the next step. This means embracing population health.

Population health means thinking about more than just the patient in front of you. Are we ready to do this? The answer to that depends on where we are with chronic disease management. CDM means more than seeing people with chronic disease in an episodic fashion. And correct me if I'm wrong but I'm not sure that this is generally understood.

We need to keep ***you*** healthy. But we need to do this for ourselves first. So that's it from me. I have to go for a walk.

James Cookman is a Canberra GP and a member of the Canberra Doctor editorial committee

Celebrating Canberra's home-grown after hours service

I have now had a fifteen year association with the management of CALMS, and I thought, to celebrate, I might provide some facts about the provision of after-hours care in Canberra and bust some myths.

The CALMS Board has kept up with national developments in medical deputising over the years through its membership of NAMDS (National Association of Medical Deputising Services). The biggest change over the last few years has been the re-organisation of commercial, for profit after-hours providers in other urban areas.

Five years ago, each major city had one to three major providers of after-hours care. Yet take-overs and mergers have occurred incredibly rapidly over the last two years, so that most of the Australian eastern seaboard cities are served by one of two companies, neither of which is owned nor run by general practitioners. Brisbane, the Gold Coast, Sydney, Melbourne, Geelong and Adelaide are now served, not just by commercial medical deputising companies, but by industrially proportioned for-profit deputising companies!

Canberra has remained out of this phenomenon to date, as its demographics are such that the favoured model for the industrialists is not palatable commercially – yet.

They favour exclusively home visit based services, and lots of them, advertising to patients directly in some cases, often using a relatively transient work-force that relies almost exclusively on 'area of workforce need' registration options. Such advertising potentially strips patients out of daytime waiting rooms as well; the industrialised home visiting model needs 20 to 30 home visits per night to make it tick for each doctor.

Canberra's geography would mean a doctor per satellite town; otherwise, petrol costs burn the bulk billed professional fee. There is simply not the clinical need for such a number of after-hours contacts, let alone home visits, to occur within the ACT. Nationally, the combined patient service numbers of these large organisations is north of 600,000 non-clinic visits a year.

CALMS, you will remember, is a non-profit company owned by Canberra's GPs. CALMS has no incentive to do anything other than what is best for the patient. Hence, it has a strong clinic based model of care provision; patients are generally best seen by an experienced doctor in a clinic setting, after hours as in hours, and home and nursing home visits are provided when needed clinically, not when it is beneficial commercially to the provider. CALMs also has a stable, experienced GP workforce of long term locums, most of whom have been or remain GPs themselves. We have more than 40,000 patient contacts a year, half of which end in a home or nursing home visit or a clinic visit. Almost all domiciliary visits by CALMS locums would require an ambulance if our locums were not available and as experienced as they are.

So, now let's do some myth-busting.

Myth 1: All home visits are good home visits. Every GP knows that doing a clinically effective and appropriate home visit is a challenge in which service provision is generally compromised. The lay community, alas, is not able to make this assessment with the same clinical focus. Naturally, many patients would prefer, on face value, a home visit to having to go to a clinic; their health is mostly better served by their attendance at a clinic, in or after hours, however.

Myth 2: All after hours care is the same. CALMS goes to great lengths to ensure that clinical information about after-hours consultations and medical events gets back to the patient's routine GP; in many cases, it is important that the GP be contacted after hours, and the extensive data base that GPs willingly entrust to CALMS allows that to occur. This trusted relationship has been established over more than thirty years, and will not exist with any other entrant into the local after-hours arena. It allows CALMS to find the 'right' colleagues when things go wrong, such as during the 2003 firestorm, 'flu epidemics, and the like, as well as keeping the Coroner's' office much quieter than otherwise it would be!

Myth 3: After hours primary care medical services of all types should be able to keep Category 4 and 5 presentations out of A&E. The casualty triage categories are based on urgency of needing to be seen. There is no direct overlap between Cat 4 and 5 A&E presentations and presentations which can or should be addressed in primary care / general practice; any overlap is purely serendipity.

Myth 4: A&E attracts patients because they have no knowledge of or access to other options. There is ample research evidence, including from the ACT, that A&E patients choose to present to A&E for many and complex reasons, and lack of knowledge about or access to other primary care options is low on the list. In most cases, patients present to A&E because they genuinely believe that it is the best place for them to be treated for their condition

Myth 5: If you do enough after-hours clinic visits and home visits, A&E presentations will fall. This is a twist on Myth 4 and also is false. Similarly, non-doctor alternatives in the after-hours period, such as the national after hours protocol-driven nurse triage service, INCREASE presentations to all after-hours medical providers, including A&Es. Most protocols seem to end with 'see a doctor inside four hours'; funny, that …

Myth 6: A 'GP in A&E' would fix all the problems. By definition, a generalist is not a GP. By all means, one might choose to put generalist medical staff in A&E. (Indeed, lots of GPs have done regular sessions in A&E over many years). However, the real issue driving long waits in A&E in the ACT is bed block; until this is addressed seriously, A&E delays will remain.

I hope you have enjoyed myth-busting with me. I would like to think that you share my enthusiasm about CALMS' ongoing critical role in the provision of primary care in the ACT, not only out of hours, but in the facilitation of quality in-hours general practice.

Ian Brown is a Canberra GP and President of the Voluntary Board of Management of CALMS

A world of opportunity and variety but importantly a Family Doctor

Recently I have begun to reflect on the variety of opportunities that have been afforded to me in my career as a GP. And so in this significant week of celebrating Family Doctors I would like to share with you just how interesting a career in general practice can be.

Rashmi at home with the children.

As I write this article this year I have just finished a three day Pharmaceutical Benefits Advisory Committee Meeting – intense discussion and thought regarding the cost effectiveness of proposed medications taking into account clinical context and budgetary implications.

What does this have to do with general practice I hear you say?

Well, general practice is the most represented speciality on the 17 person committee with three of its members being GPs. While reviewing the clinical evidence and economic models of the submissions we are also uniquely able to give the perspective of how it happens in practice, on the limitations of wordings of restrictions, on the risk of confusion in an ever expanding market etc etc.

I am also in the midst of preparing our local GP registrars for their upcoming RACGP exams through our regional training provider Coast City Country GP Training Ltd. This together with being involved in the recent interviews for the Australian General Practice Training Program fills me with hope and optimism for our future workforce, especially seeing quality local ANU graduates applying to the program.

Continuing on the education theme I am preparing to deliver workshops with the Pharmaceutical Society of Australia at the General Practice Education and Training conference in a few months' time on developing partnerships to enhance general practice training –this runs off the two resources developed by myself and my practice team, the ANU , PSA and ACT Medicare Local on supporting the role that practice nurses and pharmacists have in contributing to the training of GP registrars –this is not about role substitution but rather about gaining an understanding of one another roles and so working together more effectively centred around general practice . The resources won the National Innovation award at the GPET conference last year which was wonderful recognition of work developed locally in the Canberra region.

As a business and practice owner I am gearing up for re accreditation in a few weeks – while there are areas which are cumbersome ultimately I welcome the opportunity to refine and improve the processes that have helped my sister and I grow from a four doctor, one nurse clinic to an 18 doctor, 6 nurse and visiting allied health practice a decade later. For those with a business interest, there is room in a general practice career to build on those business skills and I take my hat off to the younger generation of GPs taking the leap into practice ownership – a brave step but certainly a rewarding choice.

And finally on the policy front I continue to advocate for the pivotal role of general practice in caring for the community as the Chair of ACT Medicare Local. Whether it be in interacting with our 1300 members, our peak bodies, politicians or ACT Health the message is the same – the value of general practice must not be undermined and undervalued – silo models and unconnected care does not serve anyone well, least of all the community. General practice is one of the most responsive and cost efficient parts of the health system.

On that note as announced in the Federal Budget, Medicare Locals across Australia will be replaced by a smaller number of Primary Health Networks (PHNs). PHNs will start operating from 1 July 2015. The ACT is expected to have a single PHN with the same borders as the ACT.

ACTML is well positioned to take this opportunity to apply to become the ACT Primary Health Network and see it as an opportunity to strengthen and build on our work serving clinicians and the community. We are in the process of inviting our members and other stakeholders to work with us to co-design the shape and function of the PHN in the ACT through participation in specifically designed workshops. We look forward to inviting GPs to a Co convened workshop with AMA ACT, RACGP and ACTML on Wednesday 30 July 6.00-9.00pm. If you're not already a member and would like to become an ACTML member, please contact us on 6287 8099.

With a constant focus on the hospital system we lose sight as a nation of the need of the generalist. The UK Commission on Generalism defined medical generalism as:

- seeing the person as a whole and in the context of their family and wider social environment
- being accessible and available to deal with undifferentiated illness and the widest range of patients and conditions
- demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population
- engaging in effective multi-professional working and co-learning
- communicating freely and clearly with patients and professionals across health and social care
- taking continuity of responsibility across many disease episodes and over time
- co-ordinating care across organisations within and between health and social care.

Now does that sound like a family doctor?

I think so and I have to say that despite all the variety I have been afforded with my career in general practice, for which I am grateful, the one thing that gives me the most pleasure is sitting in my consultation room with my patients being a family doctor ...

Rashmi Sharma is a general practitioner in Isabella Plains as well as wearing a variety of other hats!

What's it like being a family doctor in a GPsuperclinic?

The answer is probably just like any other mild mannered family GP, now with a super title (no capes please!).

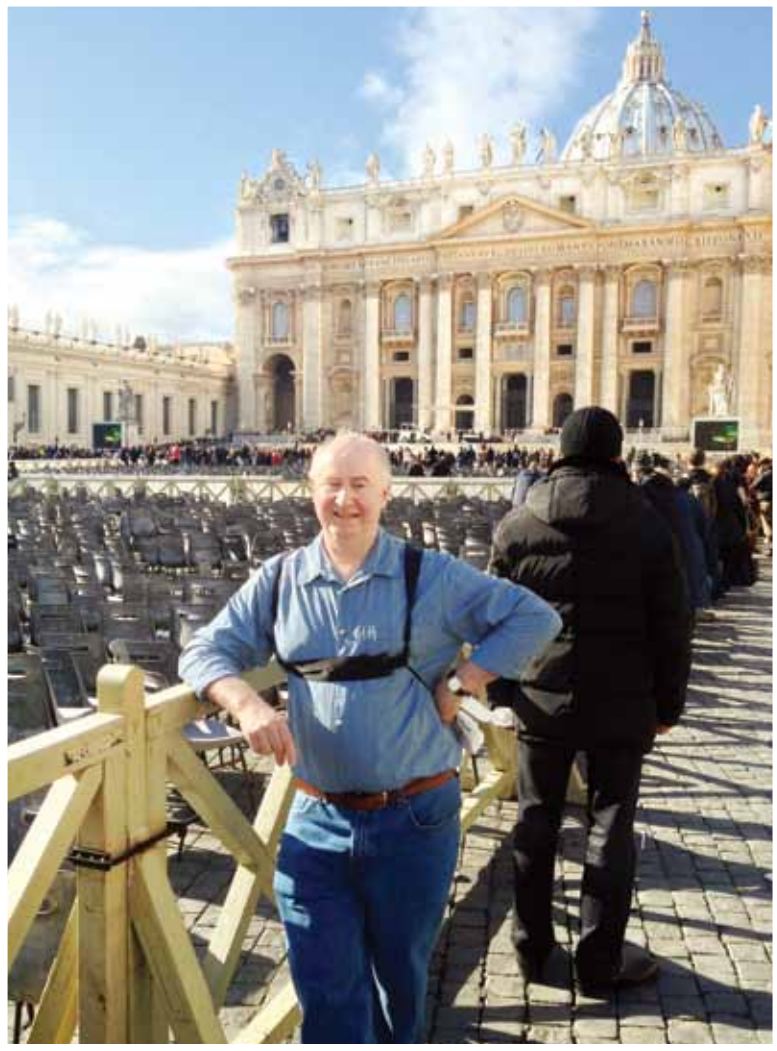
An article in Neurology published recently by Mayo clinic * describing how *lifetime intellectual enrichment might delay the onset of cognitive impairment* – I cannot think of a more stimulating and intellectually enriching occupation than that of a family doctor.

I believe the role has endless possibilities and places GPs in an incredibly privileged position of trust and with the ability to be able to guide patients through critical times in their lives. The role is becoming more complex and challenging. The working environment is changing (as always) and now one finds oneself working in a GPsuperclinic. So what's the difference – well not much really – it's similar to other corporates with a few exceptions!

In Canberra we were a bit lucky in that it became a joint venture with UC with the intent on integrating teaching and practice. This corporate has an interest in and commitment to chronic disease and teaching and is owned by a couple of rural GPs (Vs share listed). The nursing staff are all well trained RN's, keen to learn, focus on chronic disease management and use technology appropriately working with GPs (Vs some corporate who engage EN's just to make up numbers for PNIP).

Our first joint pilot research project on Diabetes with GPs and the Uni is in the pipeline "mHealth", and medical students & registrars are soon to come – so time will tell how it all goes. There is a natural tension between adequately resourcing and managing the tsunami of chronic disease and improving disease targets Vs realistic management limitations: the lean corporate mentality at times creeps in (subtly reducing staff no's – not quite 2:1 nurse to GP ratio now, meeting financial targets & budgets) but not too often so far. It's certainly a nice spanking new building with my view extending to Black Mountain and the Brumbies new HQ, and the techno toys are good (15m buys a few cryogens).

The GPs are friendly enough (a number of "transplanted" local GPs have been enticed over with their lifelong patient base) with a few refugees like myself and a couple from the UK. A significant benefit of advanced GP user-friendly practices is that the intimate system knowledge base between the GPs is much larger – knowledge of the health system is often key to getting our patients best care.



Dr Chris Harrison.

We have the luxury of a full imaging suite downstairs, pathology, allied health (both UC student led clinics and private) and soon to be on board pharmacy. Having worked in various settings over the years (from solo and group GP practice, aboriginal health services and now "GPsuperclinic"), I have a sense that we as GPs are more and more critically placed to be the core of the health system outside of hospital care. This ranges from everyday family doctor care to sorting out initial management of life changing major illness.

This is heightened in Canberra with a paucity of some specialties and horrendous wait lists sometimes even in private sector medicine. This requires (or to those GPs who are motivated and on the ball) us to really look out for our patients, make key diagnoses and serve it up on a platter to earn appropriate appointments and care. Rather than just refer to the mercy of random waitlists we can organise appropriate imaging, biopsies and make clear diagnoses with much of the work-up completed and provide a definitive clear diagnosis of, for example, a confirmed cancer presented to the specialist for more appropriate and rapid management overall.

I recently had a patient sitting at home for 5 days with an acute abdomen reluctant to attend hospital and on the same morning as the GP visit able to diagnose clearly with on-site imaging a strangulated hernia and enable entry to acute care for definitive management with a clear surgical diagnosis in and out of hospital in 48 hrs.

The model of a GP as the center of a nursing & allied care team, teaching on the go and having complete diagnostics at our fingertips is I believe the new Family GP. However much I admire the solo GP with cradle to the grave patients the challenges and expectations of being a modern GP have evolved and maybe it is the superGP in this setting rather than the GPsuperclinic that the model should be based around.

Chris Harrison
@ Health Hub, Ochre Health Medical Centre, University of Canberra, Bruce

* *Association of Lifetime Intellectual Enrichment With Cognitive Decline in the Older Population* IRST

Prashanthi Vemuri, PhD1et al JAMA Neurol. Published online June 23, 2014. doi:10.1001/jamaneurol.2014.963

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