



INSIDE

eHealth

Apps are set to play an increasingly important role in general practice

Rural health

Using flights to link patients in remote areas with much-needed specialist healthcare

Procedural medicine

Office-based procedures remain a vital aspect of modern general practice

ISSUE 7, JULY 2017

Healthcare for *homeless* patients

One in 85 Australians accessed a specialist homelessness agency in 2015–16



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Contents

Issue 7, July 2017

04

Your College

RACGP news and events for July.

06

Homeless Healthcare

Patients on the margins

GPs can play a vital role as carers and advocates for some of Australia's most vulnerable citizens – people who are homeless.

10

eHealth

Applications for health

Healthcare apps present exciting possibilities for GPs, their patients and the future of general practice.

14

Procedural Medicine

Hands-on skills

The ability to perform office-based procedures continues to be a vital aspect of modern general practice.

18

Rural Healthcare

Send me an angel

Angel Flight allows rural GPs to link patients in remote areas with access to much-needed specialist healthcare.



06



10



18



22

21

Nutrition

Bariatric surgery

Which patients should have it?

22

GP Profile

With honours

Dr Iain Nicolson has always enjoyed the rewards of being part of a rural community, as well as his many years of volunteer work with St John Ambulance.

24

Continuing Professional Development

Illustrating PLAN

Looking at how plan works and how to design your QI&CPD.

26

RACGP Specific Interests

Disability

The RACGP Specific Interests Disability network will help GPs navigate the National Disability Insurance Scheme.

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03 8699 0414
goodpractice@racgp.org.au
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Journalists: Amanda Lyons; Morgan Liotta
Graphic Designers: Beverly Jongue;
Nicholas Hopkins

Production Coordinator: Beverley Gutierrez
Publications Manager: Joe Ennis

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Advertising enquiries

Sye Hughes 0474 500 770
sy.hughes@racgp.org.au

Editorial notes

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We recognise the traditional custodians of the land and sea on which we work and live.

Cover statistic drawn from: Australian Institute of Health and Welfare. Specialist homelessness services 2015–16. Canberra: AIHW, 2016. Available at www.aihw.gov.au/homelessness/specialist-homelessness-services-2015-16 [Accessed 18 May 2017].



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On-demand telehealth services

After monitoring the emergence of various online platforms being used to deliver on-demand general practice services, the RACGP has developed a position statement on the use of on-demand telehealth services.

The statement, 'The use of secure electronic communication within the healthcare system', outlines the fact the RACGP supports secure electronic communication as the preferred and default method of communication for all health services and government agencies communicating with general practice regarding patients.

On-demand telehealth services generally consist of a website of mobile applications, with consultations being patient-initiated. Depending on the provider and platform used, patients are offered a range of services, including consultations, referrals, prescriptions and medical certificates.

The new position statement accompanies the RACGP's existing suite of telehealth resources, including clinical guidelines, standards for general practices offering video consultations, a telehealth directory, and more.

Visit www.racgp.org.au for more information and to access resources.

Business of general practice **GP17**

The RACGP has responded to member feedback and developed a number of sessions focusing on the business of general practice for its annual conference for general practice – GP17 – to take place in Sydney from 26–28 October.

These business sessions include:

- The future of general practice
- First things first
- Financial and tax management for you and your practice
- Leadership, culture and people management
- Strategic management: Growing your business
- Medico-legal: Pitfalls for practice owners
- The one-minute diagnosis? Think again!

In a further response to member feedback, GP17 will also feature sessions on building clinical skills.

Visit gp17.com.au to view the program and to register.



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afp
Australian Family Physician

New editorial board

The RACGP council has formally named Prof Moyez Jiwa as Chair of a new editorial board to guide *Australian Family Physician* (AFP), the RACGP's flagship medical journal.

Board members will be supported by a panel of international experts, with all playing an active role in guiding the AFP editorial team and assisting in the peer-review process. This will help to ensure AFP remains Australian GPs' primary source of relevant, evidence-based medical information. The editorial board members have begun their two-year terms and are working on new issues of the journal.

Visit www.racgp.org.au/afp for more information on AFP.

RACGP events calendar

July

2017

SA

Emergency update for practice staff (including CPR)

Tuesday 11 July,
7.00–9.30 pm,
College House, North Adelaide

Contact 08 8267 8310 or
megan.staunton@racgp.org.au

VIC

Intermediate Clinical Emergency Management Program – Melbourne

Friday 28 and Saturday 29 July,
8.00 am – 5.00 pm, Melbourne

Contact 03 8699 0557 or
gpeducation@racgp.org.au

QLD

Addiction medicine – A rural perspective

Saturday 15 July,
8.30 am – 4.15 pm, Bundaberg

Contact 07 3456 8902 or
sonia.minniecon@racgp.org.au

WA

Medical symposium: Controversies in general practice

Saturday 29 July,
8.30 am – 6.00 pm,
Mount Claremont

Contact 08 9489 9555 or
wa.events@racgp.org.au

VIC

Perform CPR – A workshop for GPs

Tuesday 18 July, 6.00–8.00 pm,
RACGP House, East Melbourne

Contact 03 8699 0488 or
vic.events@racgp.org.au

TAS

Sports solutions: Managing the injuries

Saturday 29 July,
8.45 am – 5.00 pm,
College House, Hobart

Contact 03 6234 2200 or
kaylene.westmore@racgp.org.au

VIC

QI&CPD PLAN information session

Wednesday 19 July, 6.00–7.00 pm,
RACGP House, East Melbourne

Contact 03 8699 0483 or
vic.qicpd@racgp.org.au

QLD

Psychodynamic principles (part 2)

Saturday 29 July,
8.45 am – 5.00 pm, Brisbane

Contact 07 3456 8902 or
sonia.minniecon@racgp.org.au

ACT

Starting a private practice – Canberra

Saturday 22 July,
8.45 am – 4.15 pm, Canberra

Contact 02 9886 4703 or
ela.duraj@racgp.org.au

VIC

Medication assisted treatment for opioid dependence (MATOD)

Saturday 29 July,
9.00 am – 5.00 pm
(registrations from 8.45 am), Ballarat

Contact 03 8699 0411 or
maryan.valverde@racgp.org.au

VIC

Family violence workshop

Saturday 22 July,
8.50 am – 4.00 pm,
RACGP House, East Melbourne

Contact 03 8699 0488 or
vic.events@racgp.org.au

VIC

Advanced Clinical Emergency Management Program – Melbourne

Saturday–Sunday 29–30 July,
8.00 am – 5.00 pm, Melbourne

Contact 03 8699 0557 or
gpeducation@racgp.org.au

Visit www.racgp.org.au/education/courses/racgp-events for further RACGP events.

AMANDA LYONS

GPs can play a vital role as carers and advocates for some of Australia's most vulnerable citizens – people who are homeless.



Patients on the margins



If it seems as though the issue of homelessness has become more visible in recent years, this perception is likely correct. One in 85 people across Australia accessed a specialist homelessness agency in 2015–16,¹ with the number of those who utilised these services increasing in almost every state and territory since 2011 (refer to table on page 8).

While people who are homeless are often the subject of concern and even fear among wider society – as evidenced by the early-2017 situation in the Melbourne CBD in which ‘rough sleepers’ in front of Flinders Street Station were forcibly removed by police following concerns expressed by members of the public and local businesses – they are also some of its most vulnerable members.

‘It is understandable that people are worried about the way homelessness presents and the perceived threat to safety, but [the public] often don’t appreciate the complexity of causative factors,’ Dr Gracie Vivian, a GP with the Fremantle-based mobile medical service for homeless patients, Freo Street Doctor, told *Good Practice*.

‘Clearing the streets of homeless people does not solve homelessness; rather, it exacerbates it. It will displace people to other areas and cause them to feel more shunned and disengaged from society at large, without even touching upon the deeper issues.’

For those who have never experienced it, it can be difficult to understand what homelessness is like or how people find themselves in that situation.

‘It may sound obvious, but it’s easy to forget that people don’t just wind up on the streets for no reason at all,’ Dr Vivian said.

According to Dr Edmund Poliness, a GP at the Living Room, a Melbourne-based primary health service for homeless people, the factors involved people becoming homeless are complex and multifactorial.

‘Most people become homeless not because of a single issue, but because of the “Swiss cheese” model of crisis, of multiple things all going wrong at the same time,’ he told *Good Practice*.

The story of each person experiencing homelessness is unique, although there are often similar patterns of disadvantage and adversity.

‘Sometimes an acute crisis has precipitated the situation. For example, domestic violence or a relationship split,’ Dr Vivian said.

‘At other times, the patient’s circumstances appear to unravel slowly; deteriorating social bonds leaving individuals without support when times get tough; unemployment; difficulty reintegrating into society when leaving jail; and, very commonly, chronic mental illness and alcohol and drug problems.

‘These reasons seem to fall into categories of physical and/or mental vulnerability, compounded by social isolation, which makes obtaining and sustaining secure accommodation very difficult.’

“ [GPs] should be advocates for our patients who are homeless ... they are people who have an issue, like any other patient ”

Barriers to care

Although people who are homeless tend to have substantially higher rates of illness than the broader population, they often lack access to effective healthcare services.²

‘For example, if you’re hungry and cold and haven’t got anywhere to sleep, you’re going to deal with those things first, not health issues,’ Dr Andrew Davies, a GP and director of Homeless Healthcare, Perth’s largest provider of health services to homeless people, told *Good Practice*.

People who are homeless may also live with depression, which can prevent them from feeling motivated to seek healthcare.³ Additionally, the stigma that surrounds

homelessness can make them unwilling to present in a traditional healthcare setting.² One way to address this latter problem is to take the treatment to the patients, which is the method practised by Freo Street Doctor.

‘[Our patients] feel welcomed, understood and not judged by our homeless-specific GP services,’ Dr Vivian said. ‘Furthermore, our services are accessible, physically in terms of being set up in central metropolitan or suburban community centres with the vans set up in a simple, non-ostentatious way; and financially, as our service is free.’

Another way to provide accessible healthcare for people who are homeless is to establish clinics in places such as community drop-in centres, a method used by the Living Room and Homeless Healthcare.

‘Doing that overcomes some of the barriers that homeless people have in coming in to see a GP,’ Dr Davies said. ‘By going to the drop-in centre, where people are fed and warm, you actually have a chance of getting them to see a doctor.’

Ensuring the accessibility of services in these ways can also help GPs build a relationship with a patient population that can be mistrustful of doctors and healthcare institutions in general.

‘A lot of patients reiterate the fact they “don’t like to see doctors”,’ Dr Vivian said.

‘This makes me mindful that building trust and rapport and creating a positive health experience is essential to ensure these patients are more likely to connect with the medical system again, and hopefully become more empowered to value and care for their own health in the future.’ >>



From left: Dr Edmund Poliness suggests GPs take a broad approach when treating people who are homeless, considering them in a ‘bio-psycho-social-spiritual’ way; Dr Gracie Vivian believes it is essential to establish trust and create a positive health experience when treating people who are homeless.

Frontline treatment

People who are homeless often tend to experience the same physical health problems as most other patients, but in greater severity.

'Everything is two to six times more common than in the general population, so you get more of it,' Dr Davies said.

Dr Poliness recommends taking a broad approach to the healthcare of these patients.

'They need good healthcare that's not only preventive, but considers them in a bio-psycho-social-spiritual way and individualises to their needs,' he said.

'It's generally bread-and-butter medicine and tends to present quite late, so diagnosis is not that difficult. But then it's more about coordinating a plan about how we're going to treat this, and what we're going to do about it.'

For many homeless patients, however, these bread-and-butter health problems are also accompanied by a range of more complex issues.

'The standard patient for us has what we call "trimorbidities" – as well as mental health and drug and alcohol problems, they have physical health problems,' Dr Davies said. 'About two-thirds of the patients have drug and alcohol issues, about two-thirds mental health, and about half of them have at least one chronic physical problem.'

Because of these multiple needs, a multidisciplinary team approach is often effective for homeless patients.

'The model we use [at the Living Room] is based around having a doctor, a nurse and various other allied health staff members,' Dr Poliness said.

'The podiatrist we work with is amazing – for a lot of homeless people, being able to get around on healthy feet is very important. We've also got a mental health nurse, a psychologist and a dual disability worker.'

When working in drop-in centres and fixed-site clinics, which encourage repeat visits by homeless patients, Dr Davies believes the best approach is to not take on too much in one consultation.

'You don't have to solve everything at the first go,' he said.

'If you try and deal with every problem and spend an hour and a half with homeless patients, they will likely quickly get tired of you. So being a good GP is chipping away at problems.'

With mobile services like Freo Street Doctor, on the other hand, patients tend to present for acute problems in more of an ad-hoc fashion. This makes it important for the healthcare team to make the most of patient presentations.

'Our GPs and nurses are vigilant at using every encounter as an opportunity for screening for chronic disease, building rapport and providing advice about preventive health, as we're not sure if we may see the patient again,' Dr Vivian said.

'Sometimes consultations may unexpectedly run on for some time, because we cover as much as we can.'

The underlying issue

The problems that can make people vulnerable to homelessness also extend beyond physical issues and mental health.

'You're more at risk if you've got poor social determinants of health,' Dr Poliness said. 'That includes poor literacy and poor ability to fill out forms properly, especially when financial pressures come up.'

'If you've got poor literacy or ability to re-finance or organise things, or explain to Centrelink why you're under these circumstances, they're the situations where you're more likely to fall into homelessness.'

These same issues also make it difficult for people to find their way out of homelessness once they have fallen into it, and homelessness has a huge impact on a person's health.² It is for this reason that Dr Davies believes it is vital for practitioners to, where possible, attempt to get directly to the heart of the matter when treating homeless patients.

'Unless you deal with the underlying problem – the fact people are homeless – you don't actually make a significant improvement in their health,' he said.

The desire to tackle the problem at its source is what drove Dr Davies to launch Homeless Healthcare.

'In late 2007 I started looking at some of the models for GP services for homeless people. I struggled because I wanted to do something different, but had no money to do it,' he said. 'Then I thought, "If I got all the right equipment and stuck it in the back of my car, then I could just go to a drop-in centre and set up there".'

'The other big advantage was working closely with the homelessness services that are trying to re-house people.'

The approach of prioritising patients' state of homelessness as an immediate problem involves having members in the healthcare team who can help patients take care of practical matters in addition to physical and mental health issues.

According to Dr Poliness, the Living Room's community development workers, some of whom have experienced homelessness themselves, are vitally important to providing high-quality holistic care.

'They do a lot of the practical things, like helping fill out forms, or re-engaging with Centrelink or other services,' he said. 'They know which services have funding for temporary housing or from which you can

Homelessness resources and information

Homelessness Australia is the national peak body for homelessness in Australia. It engages in advocacy for people who are homeless and provides information for those who want to help them.

Visit www.homelessnessaustralia.org.au to access research, information about relevant events and find homelessness organisations in your state or territory.

People who accessed homeless services across Australia

Year	2011–12	2012–13	2013–14	2014–15	2015–16
NSW	52,105	51,953	51,786	48,262	69,715
Vic	86,150	92,462	99,892	102,793	105,287
Qld	42,487	43,001	43,751	44,213	42,543
WA	21,190	21,417	21,437	23,021	24,203
SA	19,497	21,342	21,655	21,116	20,898
Tas	6148	5585	6614	7328	7859
ACT	5602	5367	5338	4987	4652
NT	6584	6959	7123	7649	8132

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Dr Andrew Davies has found creating clinics in places such as community drop-in centres to be an effective way to provide accessible healthcare for people who are homeless.

access a swag if you are sleeping rough on the street, or if you can engage patients with other people who have been previously homeless and now the patient is allowed to sleep on their couch, or share a house.'

In a further effort to house people who are living rough, Homeless Healthcare is part of a

collaborative campaign among homelessness services called '50 Lives, 50 Homes', which is trying a new approach to re-housing.

This approach involves removing the barriers that are encountered in a stepped approach. Rather than being placed in transitional accommodation with other troubled residents and required to meet strict behavioural standards before they can move on, people who are homeless are given their own space right away, as well as the support they need to cope.

"50 Lives, 50 Homes" has got much better success rates at one and two years than the transitional accommodation system,' Dr Davies said.

Reaching out

Dr Vivian emphasised the importance of remembering that every homeless person is exactly that, a person, and has their own unique story.

'When I reflect on the stories of the homeless patients I've been lucky enough to encounter, I am reminded when I see homeless people, be it professionally or just by chance as I walk around town, that each person has a story that has brought them to

this point and that there's more to the human than meets the eye,' she said.

Dr Poliness believes GPs can have a key role in helping homeless patients.

'We should be advocates for our patients who are homeless,' he said. 'They are someone who has an issue, like any other patient.'

Dr Poliness has found through his own work that, although providing care to people who are homeless can be challenging, it can also be extremely rewarding.

'I find it to be great,' he said. 'I see patients I've seen over the past eight years who are no longer homeless. They often greet me and want to tell me the stories of how things have gone for them, improvements they've made in their lives and how things have changed.'

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Applications for health

AMANDA LYONS

Healthcare apps present exciting possibilities for GPs, their patients and the future of general practice.



From top: Dr Steven Kaye has found apps allow GPs more timely access to up-to-date information during consultations; Prof Michael Georgeff believes GPs will have a gatekeeping role in recommending high-quality apps to patients.

International accounting firm and professional services network Deloitte has described apps as 'one of the most disruptive innovations of the last century' because, together with tablet and smartphone devices, they are at the forefront of a revolution in the way people carry out their daily business.¹

In today's world, apps can be used for a wide range of tasks, from banking and online purchases through to dating and learning languages, and even taking care of your health. But, while using apps in general practice might sound a bit like science fiction to some, Dr Steven Kaye, GP and member of the RACGP Expert Committee eHealth and Practice Systems (REC-eHPS), observes that most Australian GPs already use them.

'There are two types of apps: phone apps and the various programs or apps within our desktop systems,' he told *Good Practice*. 'Components of our clinical software that are innovative and improve our patient flow and systems within the practice are certainly highly valued [by GPs].'

Prof Michael Georgeff, Professor in the Faculty of Medicine, Nursing and Health Sciences at Monash University, believes GPs will find apps increasingly useful as they and their surrounding technologies continue to develop.

'I think that, particularly with the "internet of things" [the interconnection of devices such as wearables that can send and receive data] and the miniaturisation of a whole lot of health-related equipment, GPs will have a range of apps available to them,' he told *Good Practice*.

Dr Kaye looks forward to this vision of the future and its potential implications for healthcare.

'I think it's a very exciting time for fine-tuning general practice and taking it forward into the next part of the century to create

an environment of improved care for our patients,' he said.

Using apps

According to Prof Georgeff, apps will provide vital assistance as the GP's role becomes situated more within a multidisciplinary approach to healthcare.

'I think the apps developed for GPs will be ones that make team care much easier,' he said. 'Particularly if we move to the Health Care Home or a patient-centred medical





home model, we will absolutely need IT [information technology] to connect everyone and to help coordinate care.'

In addition to improving communication within healthcare teams, apps can also help GPs access information during patient consultations.

'The information explosion is impossible to be on top of for any individual, so if the GP can have readily accessible, current, up-to-date information to use, that's clearly of advantage,' Dr Kaye said.

'Therapeutic guidelines would be the main app or program used to give that up-to-date thread of information to the doctors.'

'If you know where to find the information, that's as good as having it in your head.'

By contrast, Prof Georgeff believes healthcare apps aimed at patients will tend to be less systematic.

'Many [patient-centred apps] will be stand-alone ones that don't actually connect into the system, but remind the patient about their medicines, give them advice and try and

change their behaviour in various ways, from games through to videos,' he said.

And, like their GPs, patients will also be able to access a vast amount of health information via an app. Dr Kaye feels this can potentially improve patients' health literacy and ease some burdens from GPs.

'We'd like to think that if people have information through their apps, they may see a doctor earlier should their symptoms indicate that there's something serious going on, rather than holding off,' he said.

'So certainly there's clinical advantage if the patients use the information correctly.'

But therein lies the danger: namely ensuring patients are accessing apps that provide reliable healthcare information.

'There's going to be a lot of information out there that is not legitimate, but is instead based on hearsay or small studies, unverified from poor sources,' Dr Kaye said.

'So the quality of the information really needs to be at the highest possible level in order to help in the best possible way.' >>

Recommending health apps

The RACGP has released a factsheet designed to provide GPs with information on what to consider when discussing health apps with patients. Visit www.racgp.org.au/your-practice/ehealth to for more information and to access the factsheet.



The MediTracker app is designed to provide relevant information to assist all healthcare professionals during patients' clinical handover.

>> Prof Georgeff believes that, in the future, GPs should ultimately have a key gatekeeping role to ensure patients are using high-quality apps.

'It will become more important for practices to be able to recommend certain apps to their patients,' he said. 'Over the long term, I see a role for the RACGP in, for example, being able to endorse certain apps or systems for GPs and help them understand which ones to recommend.' (Refer to breakout on page 11.)

As helpful as apps can be, it is important to keep in mind that they are an additional healthcare tool and not a substitute for face-to-face care.

'I don't think anything is going to replace the doctors,' Dr Kaye said. '[These apps are] all additive, accessories to the doctors themselves. The doctor-patient relationship

is still the absolute cornerstone of any therapeutic process.

'The apps will have positive benefits for patients and doctors in order to ascend to that very highest level of quality care.'

GP and app developer Dr Christine Colson emphasises that doctors should never become over-reliant on apps or any other type of technology.

'If doctors rely [solely] on what's in computers, that can be extremely dangerous,' she told *Good Practice*. 'I rely on the horse's mouth, which is the patient.'

'The patient is the best app available.'

“ It's a very exciting time for fine-tuning general practice and taking it forward into the next part of the century ”

Building apps

Healthcare apps are generally designed to solve an existing problem. Many GPs can no doubt think of multiple healthcare problems they would like to solve, but what is actually required when it comes to building an app?

Prof Georgeff is chief executive officer at Precedence Health Care, a company that aims to transform the care of people with chronic illnesses through broadband and mobile technologies. Precedence Health Care launched cdmNet,

an online healthcare planning service for GPs, in 2009, and this year released MediTracker, an app designed to provide a simple solution for a complex problem in Australian healthcare.

'There's a lot of evidence that poor communication during clinical handover, when out of GP hours or when the patient attends an emergency department, is one of the biggest causes of preventable adverse events and increased morbidity,' Prof Georgeff said.

To combat this issue, MediTracker provides the patient with access to their GP-recorded health information via smartphone or tablet from any location.

'It's something patients have been asking us for a long time,' Prof Georgeff said.

'It provides patients the safety [at clinical handover] of being able to correctly answer all of the questions about what medications they are on, their doctor, their care team, their latest measurements and pathology results.'

According to Prof Georgeff, apps like MediTracker may not only help to reduce poor patient outcomes, but also benefit GPs.

'We believe care should be patient-centred, but also that it should be strongly GP-led,' Prof Georgeff said. 'So the other aim of the app is to encourage loyalty to a single GP.'

'The app connects to a single GP and only the GP can change the record. So patients tend to stick with the one GP, which is what we want to encourage.'

Aspiring app developers should take note: building an app is a lot of work. Even with an entire development team and the pre-existing cdmNet platform, it took Precedence Health Care a full year to complete MediTracker.

For Dr Colson, who built her app in her spare time, it has taken a couple of



Below: tMeD app is a travel medicine app designed to help patients and GPs build travel medicine schedules according to specific countries.

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Country Alerts

SUMMARY FOR AUSTRALIA

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- Guyana
- Brazil
- Bolivia
- Paraguay
- Australia

Country Map

decades, but she is pleased with the result. Her app was designed to remedy a problem she experienced when working in travel medicine.

'We were regularly seeing people coming in on their GP's advice for [travel medicine] things they didn't need, or discovering that they weren't getting what they did need,' Dr Colson said.

While these situations were frustrating, Dr Colson does not blame GPs.

'There are myriad sources out there,' she said. 'GPs have a 10-minute or 15-minute timeslot to see patients. They have to give them general advice as well, and they can't be burrowing around in different resources trying to find out what [travellers] need for each country.'

Dr Colson recruited a developer and formed her own company, Rover TravelScript. They set about creating an app that would help GPs recommend the correct information to travelling patients, and also help them identify vaccines and medications they would need for different destinations.

The end result of Dr Colson's work is tMeD, a travel medicine reference software designed for desktop computers, and

TripGenie, an online app configured for tablets and smartphones.

'tMeD allows you to do a whole travel medicine consult from start to finish,' Dr Colson said. 'You see the patient, list the countries they're going to and work through the program to build vaccine and malaria schedules. You can print that out and the nurse administers it.'

'TripGenie has two functions. It's an information resource and it creates a travel report which tells users everything they need to know about where they're going, although it doesn't have the capacity to build those vaccine and malaria schedules.'

The initial task of collating and entering the data was a mammoth one that occupied Dr Colson seven days a week for three years. The app covers 229 countries and Dr Colson took great pains to ensure all information was correct, detailed and from reputable sources. This groundwork has laid a firm foundation for the app and its annual information updates now take a mere two or three days.

All of this background work ensures operation is as simple as possible for users.

'The information is there if the user wants to have a look at it,' Dr Colson said. 'But

the logic is done for them so, as far as working out what's required, the user only has to list the countries and then the program does the rest.'

While Dr Colson is satisfied with her finished product and believes it can be of great help to GPs, she has found the process of putting it out into the world to be almost as challenging as its creation. She has some advice for any other GPs thinking of developing their own apps.

'You have to have a very thick skin,' she said. 'You have to be resilient enough to pick yourself up after rejections and keep going.'

'It's like a constant job application.'

Dr Colson advised that having something of an obsessive nature can also be helpful.

'I work as a GP every day of the week except Wednesday,' she said. 'So I have the early mornings, lunchtimes and evenings [to work on the app]. There has to be a degree of obsession with it to keep you going.'

Reference

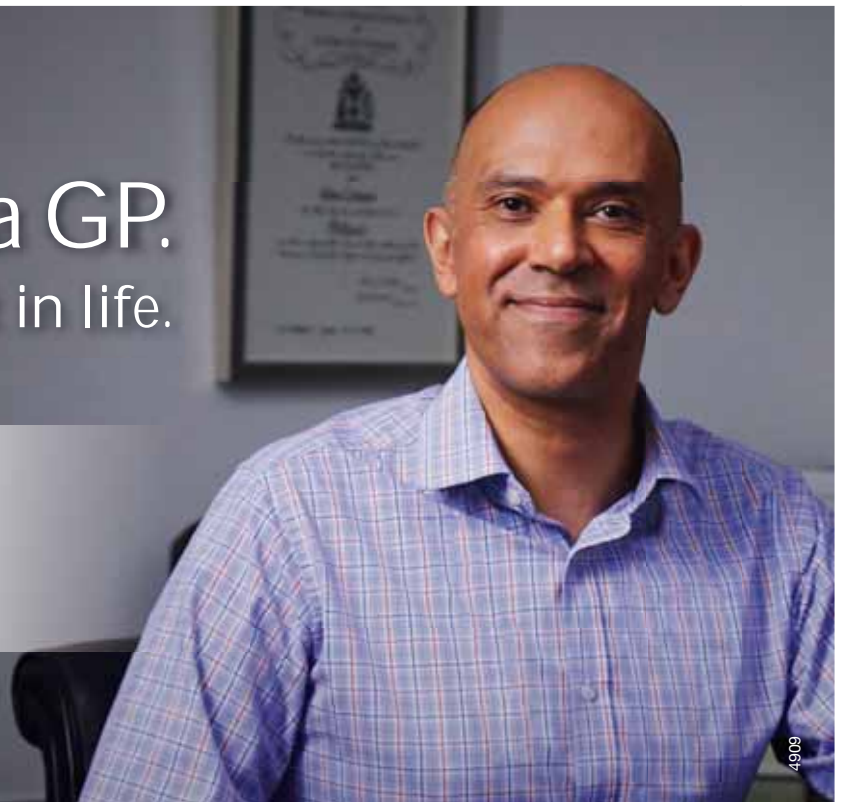
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RACGP

Royal Australian College of General Practitioners



MORGAN LIOTTA

The ability to perform office-based procedures continues to be a vital aspect of modern general practice.

Hands-on skills

As 'generalists', GPs are equipped to deliver multiple aspects of healthcare across a large demographic of patients.

General practice, like any profession, has experienced changes and developments over the years, but the GP's role in performing office-based procedures is still relevant to everyday practice. Dr Philip Clarke, a GP and dermatologist, agrees such fundamental elements of being a GP have not altered.

'General practice has certainly changed a lot recently, but some basics remain very similar: a good history and examination; compassion; and listening to the patient,' he told *Good Practice*. 'Patients also appreciate appropriate management of their problems by their GP. For example, removal of cysts, biopsy of suspicious lesions.'

Dr Clare Heal, a GP and professor of general practice with a PhD in general practice skin cancer diagnosis and management, agrees these skills remain key to GPs' work.

'Procedural skills are very important in modern Australian general practice,' she told *Good Practice*. 'Being able to do a diagnostic biopsy and perform an excision biopsy are basic skills all GPs should be able to perform well. They should be familiar with some ablative treatment techniques and basic wound care.'

In addition to skin care, other important procedural skills that can benefit GPs and patients include basic plastering and obstetrics and gynaecology.

'None of it is particularly complex, but just simple things like plastering skills are really important for general practice and for delivering comprehensive care for our patients,' Dr Chris Mitchell, GP and RACGP past president, told *Good Practice*.

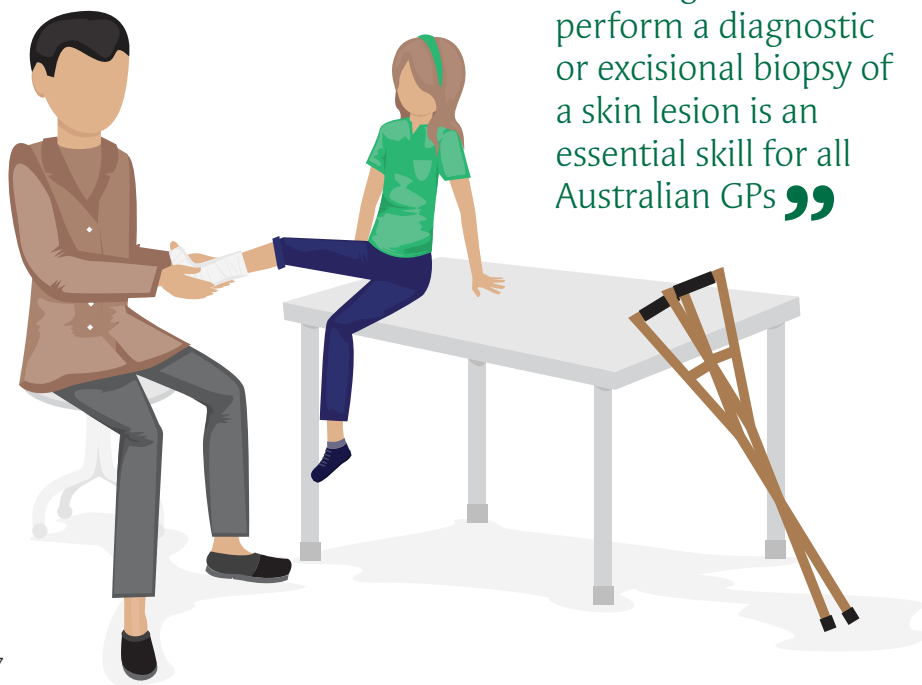
Maintaining trust

All three doctors acknowledge the advantage that office-based procedures can provide within the doctor-patient relationship. The convenience of being able to perform basic procedures during a general practice consultation can help to maintain the sense of closeness patients often share with their GP.

'That trust between the doctor and the patient, and the familiarity of knowing what [the patients'] expectations are, makes a big difference,' Dr Clarke said. 'You'll often hear from patients that they are very confident with their local doctor because they can work out when it is appropriate for them to have the procedure done.'

'That's the advantage of a closer relationship with the GP.'

“Being able to perform a diagnostic or excisional biopsy of a skin lesion is an essential skill for all Australian GPs”





From left: Dr Clare Heal feels the use of procedural skills offers GPs some welcome and rewarding diversity in their everyday practice; Dr Chris Mitchell believes basic procedural skills are fundamental to GPs providing genuine comprehensive care.

This advantage is often clearly evident with older patients, many of whom may experience some financial barriers to accessing timely procedures. Dr Clarke feels the potential pressure of having a procedure done by a specialist, rather than exploring the possibility of having it performed by their

own GP, can be detrimental to older patients, particularly in terms of adding to the cost.

'Older people often feel obliged to go along with what they are being told, rather than querying it,' he said. 'They can be sent off for something and it's cost them a large amount of money and is out of proportion to

what they can afford, even though they're happy to look after their health.

'Sometimes you can end up with possibly inappropriate care. So when patients do have a very good relationship with their doctor, who they know can deal with the majority of things, that's important.'

Dr Mitchell agrees that office-based procedures offer a number of financial benefits to patients.

'There can be big gaps, especially for patients on a pension,' Dr Mitchell said. 'The procedures [when done by a GP] are pretty well remunerated under the MBS [Medicare Benefits Schedule], so there are cost savings for patients choosing to do it.'

In addition to cost, the necessary logistics of having to travel to have a procedure performed can present an issue for patients. This is especially true in rural and remote areas, where a patient may have to travel long distances to see a specialist in a larger town or city and then return for a follow-up, which may not always be convenient.

'Being able to offer a one-stop shop for diagnosis, management and follow-up has numerous advantages and reduced healthcare costs,' Dr Heal said. >>



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>> In addition, GPs being able to follow up on their own procedural work without the need of a specialist means they can further unite the continuity of care that is so fundamental to general practice, and help make the patient feel more comfortable.

Essential training

The prevalence of skin cancer in Australia makes early detection a vital part of GPs' work, and there are many benefits in training and upskilling in this area.

'A very important aspect to general practice is identifying cancers early, especially through opportunistic examination of our patients,' Dr Clarke said. '[For example], suspicious pigmented lesions can be biopsied by a competent GP by excising the whole lesion with a 2 mm margin.'

As such, Dr Clarke believes increased training in this area would provide definite advantages to GPs and their patients.

'GPs will benefit significantly from attending active learning modules [ALMs] on dermatology,' he said. 'A lot of GPs who are still procedural are doing a lot of repair jobs on acute injuries, which in some way is a very similar thing. So that would be nice to see that a lot of GPs continue those skills and not let them pass.'

Dr Heal also supports timely training in skin cancer.

'Diagnostic biopsy and excisional ellipse are the work horses of procedural skin cancer medicine,' she said. 'I would suggest that being able to perform a diagnostic

or excisional biopsy of a skin lesion is an essential skill for all Australian GPs, especially in rural and remote areas.

'The bulk of skin cancer is managed in general practice, [so] lack of confidence and training in these basic procedural skills can lead to delayed diagnosis and poorer outcomes.

'Skin cancer surgery also offers a welcome change for the doctor from consultations and chronic disease management and, unlike many other diseases, it has the ability to offer cure. This can be rewarding for both the patient and doctor.'

With various types of training on offer to GPs, Dr Mitchell also considers the importance of GPs in rural practice, where office-based procedures are often more commonly performed due to limited medical resources.

'There is a lot of education available and a lot of interest in developing procedural skills. It is a journey and there are plenty of opportunities to improve skills,' he said. 'I think it is important for the RACGP to continue to facilitate training in minor office-based procedures, as well as supporting the procedural training for general practice, which is really being delivered through the Fellowship of Advanced Rural General Practice [FARGP].

'General practice training prepares you for all of that work, whether it's in the city or the country.'

Dr Clarke also acknowledges that GPs' ability to understand their own

RACGP resources

The RACGP offers courses across Australia to assist with GPs' upskilling in office-based procedures.

Visit www.racgp.org.au/education/courses to find the latest courses and to register.

parameters of care is an important aspect of procedural medicine.

'A lot of skin cancers can be dealt with in general practice, but some aggressive tumours or tumours in dangerous areas are best dealt with by an experienced practitioner,' he said. 'The skill of the GP is in knowing their own limits and recognising when it is appropriate to ask for help.'

Regardless of location, the presence of procedural skills in general practice remains fundamental to the principles of a GP's work, including strengthening the doctor-patient relationship and the resultant continuity of care.

'If the doctor is always thinking that they're here to treat the patient and that is the number one thing, then the other things fall into place,' Dr Clarke said. 📞



The removal of non-melanoma skin cancers is a common procedure performed in general practice.



GP17

RACGP CONFERENCE

Sydney + 26–28 October 2017 +



GP17: let's discuss the issues

GPs are often challenged with managing and screening many different types of cancer. This practical and interactive workshop developed by The Chris O'Brien Lifehouse, will be conducted in a speed dating format. Cancer specialists from all tumour streams will rotate amongst the tables to share new insights into diagnosing and managing tumours.

Cancers covered in this session will be:

- + Breast oncology
- + Gynaecological oncology
- + Plastic and reconstruction
- + Gastroenterology
- + Neurosurgery
- + Thoracic
- + Urology
- + Upper GI
- + Bone and soft tissue – sarcoma
- + Colo-rectal
- + Head and neck

This session will be held on **Thursday 26 October** from **4.00–5.30 pm**.

For more information about the GP17 program and to register visit gp17.com.au

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AMANDA LYONS

Angel Flight
allows rural GPs
to link patients in
remote areas with
access to much-needed
specialist healthcare.

People who live in rural and remote areas of Australia often have poorer health outcomes,¹ and the more remote the location, the poorer those outcomes tend to be.²

A key aspect of this disparity is the fact people in rural and remote areas are beholden to issues of accessibility to health services. This primarily takes in dimensions of availability, geography, affordability, accommodation, timeliness, acceptability and awareness.³

'People in rural and remote areas have told me they simply couldn't continue [treatment] if they had to drive to larger centres to access facilities,' Marjorie Pagani, chief executive officer of Angel Flight Australia, a charity that provides rural and remote patients greater healthcare equity through the power of flight, told *Good Practice*.

'One lady in rural Western Australia, who was in her mid-80s and driving to Perth, told me, "I can't do it anymore, I just won't go to the treatment".

'It's similar if you've got several young children at home and nobody to look after

them. You've got to take them with you on these terribly long drives.'

Such challenges in access, individually or in combination, result in approximately 20% less Medicare-funded GP activity in remote areas despite the relatively high health needs of the population.² In addition, remote Australia has 80% fewer specialists than in major cities.²

Although GPs in rural and remote areas of Australia often practise a wide range of procedural skills to help meet some of these gaps in healthcare,⁴ and can also utilise telehealth and video consultation technology to connect remotely with specialists,² there is often no option but to refer to specialists in metropolitan centres. This can present a significant challenge for patients 'in the bush'.

Such difficulties inspired the creation of Angel Flight, which has its home base in Queensland's Fortitude Valley. Founded in 2003, the charity combats the tyranny of distance by flying patients to and from their home and specialist health provider, allowing them to complete the journey in a fraction of the time and save considerably on costs.

“GPs are pivotal because they know who out in the rural communities needs help, and they can refer them to Angel Flight”



'We fly people from the country into the city for their regular treatment and check-ups,' Pagani said. 'It might be dialysis, chemotherapy, obstetrics, anything that requires a specialist trip that isn't available in the country area.'

'We try as hard as we can to get them home on the same day.'

Angel Flight is dedicated to the belief that people shouldn't have to live in larger towns or cities – or have high incomes – to receive equitable access to important healthcare.

'It saves patients time and money, and some people are not in the ambulance service so they simply can't afford the travel otherwise,' Dr Anthony van der Spek, GP and past pilot for Angel Flight, told *Good Practice*.

Vital transport

People in rural and remote areas can access day-to-day primary healthcare from their local general practice, and emergency medical services from the Royal Flying Doctor Service (RFDS). But non-emergency specialist treatment falls into something of an awkward grey area that can make access significantly more difficult.

Pagani provided an example of this when discussing the case of two pregnant women travelling from a remote community in Western Australia to the larger coastal town of Carnarvon.

'These ladies were more than 20 weeks into their pregnancies with no check-ups yet because the drive [to Carnarvon] was 14 hours over really rough roads,' she said.



Angel Flight CEO Marjorie Pagani works to help ease the potentially significant burdens of travel for people in remote areas who require specialist healthcare.

Accessing specialist healthcare can be especially stressful when it is required on a regular basis.

'It's such a strain on families to do these long trips, particularly if the patient has something like chemotherapy or dialysis, which has to be done very regularly,' Pagani said. 'The mental and welfare strain of having to undertake those long trips is enormous.'

The fact the flights are provided at no cost to the patient can also be a godsend for many people in rural and remote Australia. Additionally, there is no limit to the number of

times a patient can use the service, which is based purely on need.

'We had one young lady flying from Chinchilla [in south-east Queensland] to Brisbane for dialysis. She had no functioning kidneys and she flew with us 500 times,' Pagani said.

As referrers to specialist services, and practitioners with knowledge of a patient's context and situation, GPs are positioned to play a key role in providing access.

'If GPs know we're here, that gives them the opportunity to let the patient know there's an easier way to access their regular treatment,' Pagani said.

'The GP also knows whether that patient can manage to fly in a light aircraft, and whether that person has a need [for accessing care]. That need might be financial or it might be that they can't drive the very long distance [required for treatment]. And in many of the remote communities, there simply isn't that regular air transport system.'

'So the GPs are really pivotal because they know who's out there in their communities who needs help, and they can refer them.'

Flying for Angel Flight

The key to Angel Flight's services is volunteer work, particularly on the part of its pilots.

'We have around 3500 volunteer pilots,' Pagani said. 'They use their aircraft, their time, their skills, and they meet the bulk of the running costs.'

'We reimburse them for the fuel used on the trips, which is about a third of the cost of running an aircraft.' >>



Volunteering as a pilot for Angel Flight allowed Dr Anthony van der Spek to combine his passions of flying and helping those in need.



>> Many of Angel Flight's volunteer pilots enjoy donating their time and have racked up an impressive number of hours in the air on behalf of the charity.

'We have pilots who have numbers of flying hours up in the hundreds,' Pagani said. 'We have one based in Moorabbin in Melbourne who's flown over 420 missions for us.'

'It's an amazing effort and, of course, we are unashamedly capitalising on pilots' love of flying. And they love to be able to use their aircraft and their skills to help other people, at the same time as doing something they love.'

While it is not necessary for pilots to be medically qualified, there are a few such people who fly for the charity. Dr van der Spek is one such medico-pilot.

'I thought, "Well, that would be a good idea. I could give something back to people who have problems and use my plane and the skills I've developed to help",' he said.

A love of flying seems to run in the family bloodline. Dr van der Spek's father was a pilot during WWII and his son is a pilot for Qantas, while he got his own pilot's licence in 1977.

'I've seen a lot of Australia with the plane,' he said. 'I've been across to New Zealand a couple of times along with some friends who own similar aircraft, and around the islands near Papua New Guinea. I've moved around a bit.'

Although Angel Flight is used solely for transport purposes and no medical care is provided on the plane, Dr van der Spek believes his training as a GP has nonetheless been helpful.

'As a medical practitioner, you perhaps understand the passengers' problems a little better and you can work out if they're going to have any problems with the aircraft, mobility problems and that sort of thing,' he said.

For many Angel Flight passengers, the journey itself is vital.

'Once I had a young boy who had leukaemia and he had to go to the Royal Children's Hospital [in Melbourne], and he lived in Merimbula [a town on the far south coast of New South Wales],' Dr van der Spek said. 'He didn't qualify for ambulance transport, so it's a heck of a journey for him, whereas it's a couple of hours in the aircraft.'

'He was a bright young kid who unfortunately developed the cancer and had

Angel Flight

Angel Flight is a charity service that transports people in rural and remote areas to metropolitan centres for non-emergency specialist care. It utilises the services and vehicles of volunteer pilots and drivers from all over Australia to keep its transport free for passengers.

Angel Flight does not receive government funding and doesn't advertise or engage in traditional fundraising activities. In the words of chief executive officer Marjorie Pagani, it is 'a volunteer organisation run for the community, supported by the community'.

Visit www.angelflight.org.au for more information, or to register as a referrer, driver or pilot.

to be treated. The family was very grateful [for the service] and I felt great for doing it.'

Volunteer help is not just restricted to the sky, however. The charity also has a network of drivers who meet patients when they land in their designated location. These 'earth angels' take the patients from the airfield to their appointment at the hospital or specialist centre.

'Sometimes that's the scariest part of a big trip [for the patient],' Pagani said. 'They can come in from the country, and then they hit the city and have to get across to the hospital.'

'In Sydney, for example, the Children's Hospital is not on a train line so it means either hundreds of dollars in cab fares – which most of the patients couldn't afford – or trying to fight the way through traffic or get a series of buses.'

'It's very difficult, especially for the elderly people, or parents who sometimes have two or three young children in tow, trying to make your way through a city. And even if you do have a car, parking is difficult and very

expensive at the major hospitals. So the drive is really important for them.'

According to Dr van der Spek, registering as a pilot with Angel Flight is a straightforward process.

'You just get on the website and give them the details,' he said. 'You do have to get in touch with them periodically to show them you're up to date with your medical certificate and the routine checks that you have to have as a pilot. But that's basically it.'

The process to volunteer in other capacities, as either a referrer or a driver, is similarly simple.

'It's very easy to register,' Pagani said. 'After that registration comes in for the pilots and the drivers, we ask for some other documents that relate to their qualifications, aircraft recency, all those things.'

'But for the health professionals [who want to refer], they only have to register once as a referrer and then it's simply "send a flight request".' (Refer to breakout, left, for more information.)


Because Angel Flight doesn't fundraise in more traditional ways, it relies on community outreach to get its message out to patients and health providers.

'It's a volunteer organisation run for the community, supported by the community,' Pagani said. 'There's no government funding, nor do we ask for it.'

'But where we help people in the communities, people get to know about us. Service clubs help us, mayors put on events when they know we've been supporting people in their towns. So people help us because they know we are helping their people.'

'The backbone is our pilots and drivers, who are giving an awful lot and love doing it.'

Dr van der Spek has nothing but warm words for his experience with Angel Flight.

'It's a great organisation, it's very much a voluntary organisation,' he said. '[Volunteering is] very rewarding and we all enjoy doing it.' 

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Bariatric surgery

CHARLENE GROSSE

Which patients should have it?

Obesity is one of the most important public health issues of the 21st century. The World Health Organization (WHO) estimates that being overweight or obese contributes to 44% of diabetes, 23% of ischaemic heart disease and up to 41% of some cancers.¹

Bariatric surgery, also known as weight-loss surgery or metabolic surgery, is recognised by the National Health and Medical Research Council (NHMRC) as the most effective treatment for those with a body mass index (BMI) of >40 and those with weight-related comorbidities with a BMI of 35–40.²

The most common bariatric procedures in Australia are sleeve gastrectomy, adjustable gastric banding, and Roux-en-Y gastric bypass.³ The choice of procedure takes into account factors including age, access to follow-up and monitoring, risk profile, prior interventions and commitment to follow-up, and lifestyle interventions.²

These procedures impact or change the anatomy and, in some cases, the physiology of the gastrointestinal tract, which reduces oral intake and/or absorption of nutrients and aids weight loss. This subsequently prevents or treats obesity-related comorbidities and decreases mortality.^{2,3}

GPs will often be the first point of contact for people considering bariatric surgery, which is an option if patients meet all necessary criteria (refer to table, left).^{4,5} GPs can discuss these criteria to help guide patients in making a decision about whether to pursue bariatric surgery or try another path to weight management.

It is also important for GPs to help patients understand the surgery's required ongoing commitment, as well as expected results and any potential complications.

The rate and amount of weight loss varies between bariatric procedures, as does the resolution of comorbidities. Recent data identified a cohort of patients who were predominantly female (79%), had a mean age of 44.2 and mean BMI of 43, and 14.8% of whom identified as having diabetes.³ Of the procedures performed, 60% were for the sleeve gastrectomy and 15% gastric bands. Expected weight loss at three years after surgery was 51.2%, and 38% of patients no

longer required diabetes management one year after the surgery.³

Management does not stop with surgical intervention, however. Obesity and its management are complex and there is evidence that better outcomes are achieved when a multidisciplinary team – bariatric physician, GP, dietitian, bariatric nurse, psychologist, exercise physiologist – is involved.²

Dietitian's role

People who present for bariatric surgery may actually be in a state of malnutrition. Poor diets, fad diets, lifestyle factors and side effects from some medications negatively influence the preoperative micronutrient status of people with obesity. Preoperatively, people with overweight or obesity are at risk for deficiencies in several micronutrients, including iron and vitamins D, B12, E and C.⁵ Postoperatively, lifelong multivitamins, calcium and vitamin D supplements are recommended for most procedures.⁵

Engaging a bariatric accredited practising dietitian (APD) is a vital component of the process, starting prior to hospital admission and continuing after discharge. APDs assess patients' nutritional status, identify and treat any nutritional deficiencies, design medical nutrition therapy interventions, and provide extensive education, counselling and support.

Bariatric surgery is now more commonly used as a treatment for obesity. GPs play an important role in coordinating collaborative care with an APD and other members of the healthcare team to maximise the health benefits to the patient. Referral to and regular review by a bariatric APD are essential components in treatment. 🍎

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Criteria for bariatric surgery	
Parameter	Criteria
Age	<ul style="list-style-type: none"> • Adult • Post-pubertal adolescents with BMI ≥ 40 kg/m² (or ≥ 35 kg/m² with obesity-related complications and unsuccessful weight-loss outcomes) • Pregnancy not anticipated within 12 months of surgery
Body weight	<ul style="list-style-type: none"> • BMI ≥ 40 kg/m² without coexisting medical problems • BMI ≥ 35 kg/m² with associated obesity illness such as type 2 diabetes, hypertension, obstructive sleep apnoea, non-alcoholic fatty liver disease • BMI 30–34.9 kg/m² with diabetes or metabolic syndrome
Resistant obesity	<ul style="list-style-type: none"> • All appropriate non-surgical measures have been attempted, but have not achieved or maintained adequate, clinically beneficial weight loss
Psychological profile	<ul style="list-style-type: none"> • Undergone comprehensive preoperative assessment of psychological or clinical factors that may affect adherence to postoperative care requirements (such as changes to diet) before performing surgery • Ability to comply with and adhere to behavioural changes required after surgery • Capacity to understand the associated risks and commitment



With honours

MORGAN LIOTTA

Dr Iain Nicolson has always enjoyed the rewards of being part of a rural community, as well as his many years of volunteer work with St John Ambulance.

In 1977 Dr Iain Nicolson migrated with his wife and young son from Gosport in the south-east of England to Toora, a small farming town in Victoria's Gippsland region, to take over what he described as a 'derelict' country practice.

After seven and a half years in Toora, the Nicolson family made the move to Sale, another rural town in Gippsland, where it has remained ever since. This change helped to cement Dr Nicolson's passion for working in rural general practice, after he started his career in much the same way.

'I did my general practice training in a village practice in England, then was a partner in a general practice in a smaller provincial town,' Dr Nicolson told *Good Practice*. 'When I came to Australia it was completely different, as I went from a town of about 250 in England to 600 in Toora, but it was a fantastic experience, and one that I still enjoy.'

One of things Dr Nicolson most enjoys about rural general practice is the feeling of closeness that comes with being part of a small community.

'When you're down the street, you meet people who greet you well,' he said. 'When you're out doing other activities, you are part of a larger part of the community.'

Patron of St John

In addition to working as a GP in rural Australia for almost four decades, a significant part of Dr Nicolson's career has been his volunteer work with St John Ambulance Victoria. Starting off as a medical officer in the Sale division in 1989, he worked his way up to more senior roles such as the board director, a position he held for close to 10 years, and was appointed Commissioner for St John Ambulance Victoria in June 2005.

Dr Nicolson has never ceased to feel inspired by the services that St John Ambulance has been providing for more than 130 years, including first aid at small functions to larger events such as music festivals and international sporting events, like the Ironman triathlon.

'We offer a field hospital to support the [Ironman] competition and have some very talented young volunteers who take carriage of that and do an amazing job,' he said.

Dr Nicolson has experienced a number of major emergency situations as a volunteer. He has found such experiences humbling, particularly during the devastating 2009 Black Saturday bushfires in Victoria.

'St John played a very important part [in the bushfire response] and our volunteers were very much on the frontline of what was happening,' he said. 'It was a very difficult and trying time and our volunteers did very well.'

'I have a view that, as medical practitioners, we have a duty to the community that we look after and that is one way of repaying it.'

Dr Nicolson is quick to recommend not only GPs, but all healthcare professionals and medical students offer their services and volunteer for St John Ambulance. He believes it is an empowering experience to be part of such an important organisation that helps to foster connections across the various medical professions.

'You get medical officers, nurses, paramedics, all working together in an emergency field as volunteers,' he said. 'The carry-over from that is, when they return to their day jobs they have an increased respect for each other, and that is very important.'

'We also encourage students to join because when we're running our emergency response teams, the students get a chance to practise on real people in real time, much more so than they likely would in the normal course of events.'

Dr Nicolson recognises the significance of giving to the community as a volunteer, much like a GP does, and how it can also help to increase skill sets in general practice.

'[If you are] in general practice, being a St John volunteer stretches your skills,' he said. 'It stretches you intellectually and it stretches you in the sense that you have to work with different people and you work in situations where you're outside your comfort zone.'

'It encourages you to go on the various RACGP courses, such as the Clinical Emergency Management Plan [CEMP] workshop.'

'If you're a GP, I think it increases your scope of practice.'

Although he has taken a step away from training and volunteering with St John Ambulance, Dr Nicolson still finds time to work in smaller administrative roles within the organisation he values so highly.

'I've served my time as a volunteer, but I'm still very passionate about St John,' he said. 'I'm very proud to be a small part in a great organisation and have thoroughly enjoyed it and learnt a great deal.'

Recognising dedication

Dr Nicolson has found he also learns through his teaching, not only with his roles with St John Ambulance, but as a lecturer at Monash University Rural Health in East Gippsland. He feels it is important to pass on knowledge to the next generation of doctors.

'Taking students is part of being a doctor,' he said. 'And if you're going to do the job, you have to keep yourself up to speed with what's going on because the

students are pretty smart. Teaching keeps you on your toes.'

Further adding to his achievements, Dr Nicolson was awarded a Knight of Justice for the Order of St John Ambulance by the Governor of Victoria in 2016 – just the third Victorian to receive the honour. The award underlines years of service to the organisation and its patients.

'It was a great honour and a great privilege,' he said.

However, Dr Nicolson views the award less a culmination of his efforts than part of an ongoing journey.

'In October I will have been a GP in rural Australia for 40 years and I wouldn't swap it for quids,' he said. 'If you're prepared to put in, you get a lot out of it.'

'But you also have to give back to the community from which you derive your living.

'It's all a journey and I hope it's not over yet.'

I'm a member because ...



Because it provided me with all of the necessary tools to commence work in general practice.

I have always found the RACGP to be a very useful resource. I like the continuing educational opportunities that it provides throughout your career.

– Dr Iain Nicolson, RACGP member since 1978.



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Illustrating PLAN



RACGP QI&CPD

Looking at how PLAN works and how to design your QI&CPD.

The RACGP's Quality Improvement and Continuing Professional Development (QI&CPD) Program introduced the planning learning and need (PLAN) Category 1 quality improvement activity for the 2017–19 triennium in order to support Australian GPs to self-direct their own continuing professional development (CPD).

A mandatory online activity, PLAN is an evidence-based approach that enables GPs to identify areas of their general practice learning needs. This in turn provides the capacity to structure ongoing learning in accordance with GPs' personal requirements and the services necessary to meet the evolving needs of their patients and community.

Effective learning plans strengthen CPD

Ensuring that clinical and non-clinical competencies are up to date and documented requires periodically undertaking a comprehensive review of general practice knowledge and skills through CPD.

Effective continuing education has long been recognised as a core requirement of the healthcare profession and has become a fundamental community expectation. CPD is an Australian Health Practitioner Regulation Agency (AHPRA) requirement for

GPs, and discussions around revalidation in Australia have resulted in increasing discussions regarding demonstrating the effectiveness of CPD.

Does one PLAN activity suit each GP's unique CPD?

Successfully planning a GP's learning is a major undertaking, especially when considering the wide scope of what a GP sees and does in the course of everyday practice.

Given each GP is the expert in planning their own learning, PLAN assists individual GPs to reflect on their unique skill set and practice profile.

The planning of learning can be complex, which is why the QI&CPD Program has developed PLAN as a support to help GPs demonstrate its effectiveness.

How do I complete PLAN? What are the steps and why?

PLAN has been designed to assist GPs to map out their learning for the triennium by breaking the process down into practical, evidenced-based steps:

1. Complete a practice profile analysis and a self-reflection to identify your learning needs

2. Review the report that is generated
3. Identify areas where you would like to focus your learning and what you wish to achieve
4. Complete the activities relevant to the areas you identified
5. Reflect on the overall PLAN activity and plan ahead

1. Complete a practice profile analysis and a self-reflection to identify your learning needs

While the skills required of GPs as documented in the RACGP *Curriculum for Australian general practice*¹ can be generalised to a wide variety of contexts, each practitioner will have unique learning needs based on their practice profile. Documenting a practice profile provides a point of comparison to the Australian community to help the GP reflect on the implications of their specific patient and community needs.²

PLAN can be completed if the GP is not in clinical practice; however, they are required to consider how their learning requirements meet the needs of the Australian community.

Anecdotally, many GPs have stated that the planning of learning is of particular value when returning to practice after a period of leave. PLAN provides an ideal opportunity to

systematically review skills and knowledge prior to returning to practice.

Comprehensively self-reviewing skills and knowledge

To help document a comprehensive review of skills and knowledge, GPs are asked to self-reflect against four broad areas:

- The five domains of general practice
- Curriculum contextual units of the RACGP *Curriculum for Australian general practice*¹
- Common general practice conditions
- Procedural skills relevant to general practice

These four areas provide coverage of Australian GPs' core skills and competencies relevant to each general practice consultation.

Rating scales rationale

Rating skills allows the identification of areas that are up to date and those that require potential further study. Skills can be rated broadly or in detail according to self-reflection.

As new areas of medicine and treatment emerge, GPs complete educational activities – workshops, active learning modules, etc – in order to be better informed to address the needs of their patients. PLAN provides an opportunity to document this commitment.

Identifying an area for further study is not an admission of a lack of competency. Rather, addressing professional learning and development needs is a core general practice skill (refer to CS4.2.1.1 of the RACGP *Curriculum for Australian general practice*).¹ This will be especially important for GPs returning to practice who identify a need for re-training, or who believe greater expertise in an area will support better patient outcomes.

A self-reflection rating is best completed early in the QI&CPD triennium in order to provide the basis for reflective learning for

the remainder of the triennium. It also allows sufficient time to undertake the learning required to meet identified needs.

2. Review the report that is generated

Once the self-reflection is complete, a report is generated that can highlight what the GP has identified as potential areas for revision.

GPs can select preferred learning areas to customise their PLAN activity, regardless of how they rated the areas (ie low, medium, high).

Documenting learning choices based on self-reflection demonstrates and records that the GP has reflected on their learning needs.

3. Identify areas where you would like to focus your learning and what you wish to achieve

After reviewing the self-reflection report, the GP can select up to five learning areas on which to focus continuing education. This is achieved by stating learning outcomes related to selected areas and strategies, and understanding activities used to meet these outcomes.

There is also an opportunity to fill up to three additional areas of learning. This may be of use for GPs with special interests beyond the core skills of general practice, but which are still relevant to their scope of practice.

Opportunity for peer review

Once learning outcomes and strategies have been identified, PLAN has an option to generate a 'Peer review report' in the event the GP wants feedback.

Peer review is effective for obtaining feedback to confirm that learning is on track. A trusted, independent opinion can provide reassurance that learning relates to their self-reflection and scope of practice.

While not compulsory, peer review can help to ensure the GP's learning takes into account their knowledge and community needs.

4. Complete the activities relevant to the areas you identified


Once learning strategies have been identified, the GP can undertake activities in accordance with their learning plan. They can upload evidence of completion as activities are finished. The GP can link QI&CPD-accredited activities to PLAN, and upload evidence of activities that don't attract QI&CPD points.

After uploading evidence of completion, the GP can review and reflect on how the learning has contributed to meeting the outcome. This demonstrates the deliberate planning process involved in remaining up to date with professional learning.

This process that will occur throughout the triennium. The GP can return to PLAN at any time to add to evidence and reflections.

5. Reflect on the overall PLAN activity and plan ahead

Once the outcomes are completed, the GP provides an overall reflection on their learning prior to submitting their PLAN for QI&CPD points. This is best done towards the end of the triennium, when the GP has had time to meet their learning outcomes.

Meeting all learning outcomes by the end of the triennium is not mandatory, as the reflection on the outcomes is the key aspect of learning. 

References

1. The Royal Australian College of General Practitioners. RACGP Curriculum for Australian general practice. Melbourne: RACGP, 2016. Available at www.racgp.org.au/education/curriculum/2016-curriculum [Accessed 5 June 2017].
2. Britt H, Miller GC, Henderson J, et al. General practice activity in Australia 2015–16. Sydney: Sydney University Press, 2016.

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Disability

AMANDA LYONS

The RACGP Specific Interests Disability network will help GPs navigate themselves and their patients through the National Disability Insurance Scheme.

Dr Bob Davis, GP and inaugural Chair of the RACGP Specific Interests Disability network, has a comprehensive understanding disability after more than 30 years' experience in the field.

'Disability is an umbrella term for impairment, activity limitations and participation restrictions,' he told *Good Practice*.

'It [describes] the interaction between the environment and personal factors.

'A person may start off with a health condition, disorder or disease that impacts the body structure or the way the body functions, and that will in turn impact on the type of activities the person can do and their participation in the community, be that their job, recreation or whatever else.'

People with disability and their advocates within the healthcare profession have long argued that Australia's system for providing disability services needed major reform.¹ The federal government's Productivity Commission carried out a public inquiry into the issue in 2010 and, as a result, July 2013 saw the launch of the National Disability Insurance Scheme (NDIS) in trial sites around Australia, followed by its progressive rollout across the country from 2016.²

'I think the NDIS is going to change the face of disability,' Dr Davis said.

'People with disability are going to be more supported in participating in the community,

but they will also need the health support to go with that.

'Those health supports will need to be community-based, where the GP lives, rather than institution-based.'

Network launch

Given the belief that the NDIS will be such a major step forward for people with disability, their carers and GPs, Dr Davis and his colleagues were inspired to create the Disability network to help GPs navigate themselves and their patients through the new system.

'GPs are an important source of information as part of the assessment process [for the NDIS],' Dr Davis said. 'They are able to give information about the current status of a person's illness that is causing the disability, and what the future prognosis might be.

'I'm working with some colleagues to draw up information protocols for GPs, so if they are approached by NDIS they can support the patients in those applications. At the moment, a lot of those issues are being dealt with in isolation and there hasn't been a systematic approach. We're hoping to change that.'

The network is still in the early stages of development and has been focused on defining its identity and goals (refer to breakout, left, for its mission statement and main aims).

Dr Davis has also been involved in a number of education programs in disability, including the development and updating of the RACGP's curriculum statement on the subject, and has plans for further educational activities in the future. He believes GPs have an important role in the lives of patients with disability and intends the network to help GPs as they help their patients.

'We see [the network] having a role as an interface between disability services and general practice,' he said. 'I think GPs are generally highly regarded by patients with disability and have relationships with their patients that are particularly important.'

References

1. Australian Department of Human Resources. Our history. Canberra: Australian Department of Human Resources. Available at www.ndis.gov.au/about-us/our-history [Accessed May 9 2017].
2. National Disability Insurance Scheme. When is the NDIS coming to you? Canberra: NDIS. Available at www.everyaustraliancounts.com.au/about-ndis/rollout [Accessed May 9 2017].

About the network

The RACGP Specific Interests Disability network was endorsed in February 2016. It was formed in response to coming changes to the provision of care for patients with disability under the National Disability Insurance Scheme (NDIS).

The Disability network has a mission statement to inspire GPs to provide high-quality healthcare that is accessible to all people with disabilities. Its main aims are to:

- promote an understanding among all GPs of the health vulnerabilities and needs of people with disability
- encourage active debate, discussion and reflection upon improving healthcare access and delivery for people with disability and their families
- lead GPs in the improvement of the quality of healthcare for people living with disability
- develop appropriate resources and educational materials for GPs and support staff
- provide the RACGP with advice on government policy and service provision issues relating to the healthcare of people with disability.

Visit www.racgp.org.au or contact gpsi@racgp.org.au for more information, or to join the network.



Let's get started.



The **PLAN** activity is available now

The Royal Australian College of General Practitioners (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program for the 2017–19 triennium has introduced the Planning learning and need (**PLAN**) activity.

PLAN is a mandatory online Category 1 quality improvement activity designed to assist you in mapping out your learning needs for the triennium, while encouraging reflection of your education in general practice.

Start your **PLAN** activity via myRACGP log in at racgp.org.au/myracgp

For assistance in starting your **PLAN** activity, please contact the RACGP QI&CPD Department on 1800 4RACGP | 1800 472 247.

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