RACGP

PEP Specialist Stream – Reflective Task Example 1:

The PEP program has helped me with learning how to be a general practitioner in Australia from a clinical, administrative, and cultural point of view. The resources provided are very helpful to address the differences from where I practiced previously (New Zealand) and to consolidate all the information required to manage daily practice.

The general practice I have been working in is in a small rural town (Modified Monash Model score of 5 for remoteness). There is a higher proportion of geriatric and unemployed population in this practice. Compared with my previous practice, my current practice case-mix involves more emergency care such as accident and injuries, procedural work such as skin cancer excisions, and requires more engagement in improving patient's health literacy and managing chronic and complex medical conditions. Working in a rural country general practice in Australia has exposed me to a vast mix of clinical presentations. Of note are the zoonotic diseases such as Ross River, Q fever and Japanese Encephalitis, which I have never encountered with my previous metropolitan practice.

The health disparities and inequalities relating to Indigenous peoples' health in both Australia and New Zealand are equally prominent, despite the geographical distance and the varying histories. Chronic health conditions and youth suicidal rate are increasing in both countries and this is especially prominent in the Indigenous people. The Māori population has slightly more privileges compared to the Aboriginal and Torres Strait Islanders (ATSI) in all aspects, including health initiatives and health programs to improve health inequality and life expectancy.

The clinical management guideline for most health conditions, such as in emergency, is relatively similar between Australia and New Zealand. The resuscitation algorithm and drugs used are the same as the guidelines are shared between the countries. The preventative healthcare guidelines outlined by the RACGP Red Book are like NZ practice with some variation such as timing of cervical screening and colorectal screening.

From an ethical perspective, the RACGP and Australian medical board guidelines are very similar to the RNZCGP and NZ medical council guidelines. Ethical practice including professional boundaries and behaviours towards patients and colleagues are similar. The medico-legal aspects such as patient's rights and capacity for consent, managing patient's confidentiality and complaints, as well as death reporting process are very similar.

One difference between Australian and New Zealand general practice is the structure of the health care system and the Medicare health insurance system. The Australian health care system is jointly funded by local, federal and state governments, allowing eligible Australian residents access to health care at affordable cost or no cost, along with the option of a subsidized private sector healthcare. The introduction of Medicare since 1984 has provided equal access to cover all cost of public hospital services and some of other health services such as GPs, medical specialists, allied

health, nurses and dental services for children. GPs are responsible for services billed under the correct Medicare billing code. Some general practices offer bulk billing while others have a mixed private and bulk billing options. Bulk billing is where a practice accepts the Medicare rebate only as payment for service and the patient may agree for this to be paid directly to the practice. Private billing is where patients are charged more than the rebate paid by Medicare for the provided service, known as 'gap payment'.

In New Zealand (NZ), General Practices are private businesses and set their own fees for consultations and other health services; in accordance with thresholds agreed by District Health Boards and Primary Health Organisation (PHO). Some practices join a Very Low-Cost Access (VLCA) programme run by PHOs where government funding is provided to the practice directly to keep patient fees at a low level for enrolled patients. Most practices offer zero fees visits for aged 13 and under, and cheaper visits for all community service cardholders and their dependents.

The remoteness of my current practice meant more challenges to face and more resilience necessary to overcome these challenges. One of the challenges I have found is the limited secondary and tertiary healthcare service available locally for optimisation of patient healthcare. The nearest large hospital with major health services available is about 100km away (Toowoomba). The local rural hospitals, at times, have inadequate staffing and lack some services. Medicare bulk-billing healthcare services options are very limited locally including psychology and allied health. A long waitlist usually follows upon referral or sometimes rejection from referrals due to an overflow in booking. A private referral is an option but most patients in the town I work are from a low socio-economic background (unemployed or pensioners), who cannot afford to pay for such services and may have issues accessing transport to get to health services. I have had to become more resourceful to search for alternative options for these patients, such as seeking DVA funding, or sourcing Telehealth consultations to help with transport issues.

There is a relatively high degree of opioid and benzodiazepine use among patients in my current practice. I have found this challenging to manage, especially with the discussion of weaning them off these medications. Many are patients who have been on opioids and benzodiazepine for years, and I 'inherited' these patients when I joined the practice. It was challenging initially as I was a new doctor to these patients and had inadequate rapport with these patients. Rapport is particularly hard when patients' prescription expectations are not met, but over time and with relationship building, I was able to negotiate a management plan with most patients including a discussion on rationale for discontinued use of these medications and/or goals for tapering of the doses where tolerated. There is still a minority of patients who are resistant to plan negotiation and insistent on continued high doses of these medications. With resources from PEP program and the RACGP guidelines on S8/drug of dependence prescribing, I am more confident in managing these patients and aware of contact details available to seek for advice or second opinion for complex high-risk users. The Q script online learning system is a good resource to assist with opioids and benzodiazepine prescribing for my

patients as it allows me to keep track on patient dispensing history. I am thankful for the pathways to refer patients to chronic pain or ATOD services for those patients who are difficult to manage.

A significant problem with my current practice is the patient management software. Correspondence from other health care providers, pathology, radiology, or the department of health seem to be variably lodged in different places of the program because of automated systems combined with human filing systems. This has created significant time wastage, as we must comb through all the different tabs to tease out relevant data. There is a potential risk of information going missing and lost to follow-up, such as with important investigation results or pathology requests being lost to follow-up due to inadequate user alerts within the software. This can cause significant compromise in patient care. To combat this potential loophole, I keep a written task list to check important test requests made and ensure that patients always arrange another appointment at the front desk (for results review and to prevent them being lost to follow-up). A better patient management software package can be considered. My previous practice's patient management software has easily identified tabs for clinic letter correspondences, radiology and pathology results. The software program also incorporated an automatic trigger system with reminders on all test requests made to reduce risk of patient loss to follow-up.

One of the key learning points from completing the PEP learning units is the Medicare billing and claiming process. I have developed a better understanding on claiming responsibilities including use of the correct Medicare item codes for services provided. Medicare Benefit Schedule has a list of subsidized medical services, with correct billing codes readily accessible online for references on MBS online. Penalties may apply for incorrect claimed services. Services Australia website has contact details and resources to assist health professionals with Medicare billing. Besides, I have come to familiarize with various health benefit card entitlements available to patient including pension and unemployment benefits, as well as other healthcare funding options available if non-Medicare funded services access required, such as the Department of Veteran's Affairs (DVA) and Workplace health and safety indemnity.

Another key point learned is safe prescribing process and regulations, including S8 medication prescribing. Therapeutic Goods Administration (TGA) online has information on medication scheduling basics to help understanding on medication classification system in Australia. Both Pharmaceutical Benefits Scheme (PBS) online and RACGP guideline have resources to help GP with S8 prescribing including PBS authority application rules for S8 prescription and strict legislative requirements involving request for prescribing approval from the Chief Executive at Queensland Health for drug dependent individuals. In Queensland, it has become mandatory for prescribers to review online real-time prescription monitoring system (Q script) prior to prescribing, dispensing, or giving a treatment dose monitored medicines such as S8s. The Q script online learning portal serves as a good platform for GP to be familiarized with this system.

An important learning point for me is the impact of historical experiences and intergenerational trauma on the Indigenous peoples' health. The resultant fear of discrimination and loss of cultural identity are potential contributing factors for poor healthcare access for ATSI people and high rates of chronic health conditions such as diabetes, anxiety/depression, drug use and alcohol binge. With this knowledge, I am more culturally aware and sensitive when providing healthcare to ATSI patients, cultivating a holistic approach involving the local ATSI community as it has been suggested that the strength of the Indigenous cultural community to be a protective factor in prevention of chronic disease and mental illness. There are health initiatives and community services available under Medicare funding to assist with health preventative measures and emotional wellbeing for the ATSI people, which should be utilized.

One of the key aspects for my future learning is medicinal cannabis prescribing. Medicinal cannabis is an emerging therapeutic modality that has seen significant uptake across the world. Potential therapeutic areas include but not limited to management of chronic pain, multiple sclerosis, epilepsy, palliative care, anxiety, chemotherapy induced nausea/vomiting. In Australia, medicinal cannabis is available for management of certain conditions and prescribers must apply to the TGA under the special access scheme to prescribe cannabis compounds to patients (via their portal). I will need to do more research on the efficacy of medical cannabis and attend webinars or courses on this topic before I feel more comfortable prescribing these medications. Evidence based systemic review journal readings such as from Pubmed is another helpful resource for my learning on medicinal cannabis.

In line with the government's 'Closing the gap program' to achieve health equality and life expectancy, I wish to learn more practical ways to work towards this goal in daily practice. ATSI peoples view health as being connected to community and connection to the land. I plan to engage with the local Aboriginal Community Controlled Health Service and Aboriginal Medical Services which are in Kingaroy, to identify social, emotional, mental and physical health needs that I can address to provide this holistic care. I aim to also research 'Closing the gap' initiatives and outreach programs. Some patients have approached me with the question of wanting gene testing to identify if they have a genetic risk for cancer. Currently my knowledge extends only to tumour markers in serology and identification of the BRCA gene. I would like to have a better understanding of genetic testing available and to become more confident in offering advice for patients, for instance, in pregnancy planning and those requesting personal gene testing. My research on this will be from RACGP guidelines, National Health and Medical Research Council (NHMRC) resources, Medline, Google and local medical institutes.