Going Places
Network
Taking a fresh look at general practice

John Murtagh
The man behind the books

Also in this issue:
What you can earn
Good prescribing
GP profiles
Clinical cases
Welcome

Welcome to the 12th issue of Going Places magazine, proudly brought to you by General Practice Registrars Australia (GPRA).

Our cover story is an interview with Professor John Murtagh. I first met John at the national RACGP conference in Hobart a couple of years ago. I introduced myself and we talked about GP training while deferentially addressing him as “Prof” several times. After all, he has authored arguably the most influential textbook for GPs and even has a library named after him. He told me about his early years in general practice, working in Gippsland. Halfway though the conversation, he paused, looked me in the eye and said, “Please, call me John.” I was taken aback slightly. Not only did he take time out to have a personal chat with me but also insisted that I call him by his first name. I left that encounter impressed by his unpretentiousness and friendliness.

We are privileged to have John share with us his general practice journey.

In this issue, we have many more interesting profiles of GPs and GP registrars.

Dr Guy Sanson’s journey to become a doctor is one of grit and determination. He tells us how he changed his line of work, from farming to becoming a doctor. Did you know there are Australians who speak Tiwi? Read Dr Clinton Leahy’s profile, and you might be able to learn a word or two.

Professor Tarun Sen Gupta explains how man’s best friend will benefit your rural general practice career. Melbourne GP Dr Sarah Matsson tells us why she enjoys working in a busy urban practice, and GP registrars Dr Stephanie Barnard and Dr Gerry Considine share with us their stories about working at the coalface of general practice.

Dr Abby Gleeson tells us how her Prevocational General Practice Placements Program (PGPPP) term in Tasmania cemented her decision to pursue a career in general practice.

And in ‘Aqueous Humour’, Dr Marcus Gunn recalls an incident that will surely tickle your funny bone!

I am pleased to announce that Going Places magazine is now available on your iPad. It can be downloaded free from iTunes by simply searching ‘Going Places magazine’. The app version of the magazine has some amazing features, including more images, audio and video, and a zoom-in feature for clinical photographs.

I hope that you enjoy this issue of Going Places, and be both inspired and entertained by the stories and articles we have prepared for you.

Dr Chia Pang
Medical Editor
GP registrar – Bogong Regional Training Network

©2013 GPRA. All rights are reserved. All materials contained in this publication are protected by Australian copyright law and may not be reproduced, distributed, transmitted, displayed, published or broadcast without the prior permission of General Practice Registrars Australia Ltd (GPRA), or in the case of third party material, the owner of that content. No part of this publication may be reproduced without prior permission and full acknowledgement of the source: Going Places magazine, a publication of General Practice Registrars Australia. All efforts have been made to ensure that material presented in this publication was correct at the time of printing and is published in good faith.
Have you ever given thought to working as a GP registrar in an Aboriginal and Torres Strait Islander health training post?

These posts can be undertaken as part of the Australian General Practice Training (AGPT) program. Talk to your regional training provider today for more information or go to gpet.com.au
Emeritus Professor John Murtagh has been called the J.K. Rowling of general practice due to his magic touch with bestselling medical textbooks. Here we leaf through the pages of the prof’s long life in medicine, teaching and writing.

Almost every month I go somewhere in Australia to give a talk to students or the registrars at GPRA,” he says. “I’m the author of a book they read. They want to meet the author; so I rotate around at various universities.”

It’s not unusual for the prof to be mobbed like a rock star by young admirers. “I enjoy teaching the undergraduate students because I’m still learning all the time. I learn from the students,” he remarks. “They’re very interesting, gifted people.”

Prof. Murtagh’s lexicton is a global one. He has just returned to Australia after delivering a lecture to international doctors at Monash University’s Prato Centre in Tuscany, Italy. China, too, is frequently on Prof. Murtagh’s itinerary. He is a guest lecturer at Peking University, Beijing through a Monash University, China partnership program. He is also headhunted back to Melbourne to take up a full-time lecturer position at Monash, teaching a cradle-to-grave general practice.

The prof’s retirement is not all work and no play. A devoted Hawthorn supporter, he also enjoys birdwatching in the bush, couch time with historical documentaries and family time with his wife, five children and seven grandchildren. So any final words of wisdom from the prof? The answer reflects his humility and heart. “My motto is ‘Share and care’ — share with colleagues and care for all.”

Written by Jan Walker

Taking a fresh look at general practice

COVER STORY

THE MAN BEHIND THE BOOKS

John Murtagh has officially retired. But you would never know it.

For a septuagenarian ‘retiree’, he sets a cracking pace. People keep asking him to do things, he says, and he is happy to oblige.

He works in an honorary capacity as a lecturer and examiner in his emeritus professor role with Monash University.

John Murtagh grew up in country Australia — they took over a solo practice at the setting of Coleraine in the western district of Victoria. John trained many visiting Monash medical students there, and his ability as a natural healer arts he would later emulate. “The Christian ethic is very tied in with medicine;” he says. A little later, he met his future wife, Jill Rosenblatt, a fellow med student who had also grown up in Victoria’s western district. The pair would become partners in their private and professional lives, and John says Jill is his greatest inspiration.

Both are driven by a strong Christian faith. “The Christian ethic is very tied in with medicine,” John reflects.

On completing their studies — John undertook a new pilot general practice training program and surgical training — they took over a solo practice at the hospital in Neerim South at the foothills of the Great Dividing Range in 1969. John brought surgical skills and Jill anaesthetics, and they immersed themselves in cradle-to-grave general practice. “It was good because we were a team. We had our own surgery, we ran the hospital and it was a wonderful experience for us for 10 years,” he says.

John trained many visiting Monash medical students there, and his ability as a natural educator was noted. In 1979 he was headhunted back to Melbourne to take up a full-time lecturer position at Monash, bringing together his twin talents as a doctor and teacher. He would later become Professor of General Practice at Monash until his retirement in 2007.

In the 1980s, 90s and beyond, John’s prodigious works as a writer and editor took off. He was enlisted to edit Australian Family Physician (AFP) and introduced popular new features such as Brain Teaser, ‘Practice Tips’, ‘Patient Educator’ and ‘Cautionary Tales’. These would become the seeds of a stack of Murtagh books to follow.

Prof. Murtagh’s magnum opus General Practice has its own backstory. Publishers McGraw-Hill identified the need for a new medical textbook that defined the nature and content of general practice. They approached John to write it in 1991. “I could see the need for it and I thought I’d have a go,” he says. At times he questioned whether he had bitten off more than he could chew. The first edition was published some three years later in 1994, and John considers it to be his greatest legacy. “It became a sensation, because it was different. It was the first time a textbook had chapters based on symptoms rather than disease categories — kidney disease, heart disease and so forth,” he says.

The approach grew from a diagnostic model developed by Prof. Murtagh, pitched at the way undifferentiated disease presents in a GP’s consulting room.

Prof. Murtagh continues to write medical books with his wife Jill. Many titles such as their latest, Flashcards, have morphed from books to apps. He is acutely aware that he can’t go on forever and he is working on a succession plan to ensure that new editions of Murtagh carry on.

The prof’s retirement is not all work and no play. A devoted Hawthorn supporter, he also enjoys birdwatching in the bush, couch time with historical documentaries and family time with his wife, five children and seven grandchildren.

So any final words of wisdom from the prof? The answer reflects his humility and heart. “My motto is ‘Share and care’ — share with colleagues and care for all.”

Written by Jan Walker
The right path for Abby

Dr Abby Gleeson was always 90% sure she wanted to pursue a career in general practice. Now, in her second PGPPP rotation, she is 110% sure!

What year are you in?

I am currently a PGY3 completing my second resident medical officer year on the general training scheme at Royal Hobart Hospital, where I have worked since my internship in 2011.

You have done two PGPPP rotations: Lauderdale and Rokeby in Tasmania. How was the experience different in each location?

I completed my first PGPPP rotation last year at Lauderdale (about 25 km outside of Hobart), and am now completing my second PGPPP at Rokeby which is about 5 km down the road from Lauderdale. It’s amazing how close communities can be in terms of distance, but how far they can be in terms of health issues.

Lauderdale is a relatively large private practice co-owned by four GPs, and has a workforce of six senior GPs, 2–3 GP registrars at different levels of their training, one PGPPP and a full-time nurse. Rokeby is a private practice co-owned by two full-time GPs, and has 1–2 GP registrars and one PGPPP. Despite the different sized workforces – they have similar numbers of patients. Both rotations have been fantastic, and by far my favourite time spent as a junior doctor has been while on a PGPPP rotation.

Were there any similarities between the communities and their health needs?

There were definitely some similarities, especially the children’s health problems and the general issues with obesity and metabolic syndrome. As a young female doctor, I saw a lot of women’s health issues, which I received a lot of experience with the Close the Gap scheme.

How was it meeting your supervisors for the first time? What did you learn from them?

I was rather nervous meeting my supervisors initially, but soon found them to be very approachable and keen to teach. All my supervisors were experienced in different areas (women’s health, men’s health, paediatrics, skin and chronic medical conditions). With the aid of my supervisors I developed increased confidence in managing a range of conditions, most of which I had no previous clinical experience in having come from a hospital medical background. I also learnt that being supportive of junior doctors is essential to build your practice. I loved both practices so much I would definitely return to work at other or both in the future, and the support I received plays a large part in this desire.

Tell us about some of the work you have done during your placements.

Where do I start? I have diagnosed Addison’s disease, alcoholic liver disease in a 19-year-old and strokes. I have managed dental conditions, diabetes, heart failure and kidney disease. I have biopsied skin lesions, done Pap smears, given vaccinations and completed many GP management plans and mental health care plans. I have done nursing home visits and once, on returning from a day at Nubeena with another GP was the first on the scene at an MVA.

Did you get some ‘hands-on’ experience?

Plenty! Skin biopsies/cryotherapy and lesion removal giving immunisations and other injections assisting in an ingrown toenail removal treating chest pain … the list goes on. I even managed an elderly gentleman during a lunch break (while everyone else was out), who had amputated three of his fingers while working at his winery and then drove to the practice on his tractor.

Describe an average day during your PGPPP.

An average day begins at 8 am and finishes at 5 pm (four days a week), and consists of seeing my own patients and feeling like a real doctor! On both rotations, I started seeing two patients an hour and over a few weeks worked up to 3–4 per hour. I receive clinical teaching for three hours a week, which has consisted of discussing my patients, any issues I have, teaching on commonly seen conditions in general practice, and even some skin lesion removal/histology practice. There is generally plenty of opportunity during the day to discuss cases with other doctors and my supervisors are always available.

What are some of the important lessons you have learned about patient care?

The more attentive and caring you are the better results you will get for your patients. If you are considerate and go out of your way to help someone they will appreciate it and be more likely to follow your advice. Quite often patients will ‘test’ you out to see if they trust you or like you before they open up. On a couple of occasions I have had patients tell me “it’s so nice to have a GP who actually takes the time to hear me out instead of just giving me a script and rushing me out of the room”.

What have you learned about general practice?

Expect the unexpected and don’t fear your abilities. It is such a versatile rewarding career, one where you really can make a difference … and you never stop learning.

Did anything surprise you about the PGPPP experience?

How tiring some days can be. Sometimes it’s mentally draining when you have days of seeing complicated patients … you even look forward to a simple cough and cold on these days. It is such a variable career and certainly only a small minority of day-to-day cases are the simple viral illness. If anyone says to me now that general practice is all coughs and colds, I have great pleasure informing them just how wrong they are!

Did the experience make you want to pursue a general practice career?

Most definitely! I was 90% sure I wanted to pursue a career in general practice before my first PGPPP; after my first day I was 99% sure, now I’m 110% sure. I have loved every minute of it!

What was the best part of the experience?

Developing my own patient clientele. There is a certain satisfaction when you see your first patient returning to see you. I think that’s when you know you’ve made it. You can really develop a rapport with patients and I think this is extremely important in patient care. Also, the staff at both practices have been phenomenal. My supervisors have a wealth of knowledge (as do the rest of the doctors), and the other staff are simply delightful and always willing to help. What was the most challenging or difficult?

Surprisingly, it was learning to treat common general practice conditions. Before starting my PGPPP I had never seen impetigo. Now I see it all the time! Also, being at the front line of managing and diagnosing conditions such as diabetes and chronic kidney disease. As a hospital doctor, most patients are already diagnosed and commenced on medication. In general practice, you are often the one diagnosing and deciding on appropriate treatment.

Would you recommend a PGPPP to others?

Definitely! It is fantastic if you are considering pursuing a career in general practice, as it gives you a three-month taster into exactly what you will be facing. Even those not really interested in doing general practice should consider doing a PGPPP’s good experience to learn to manage common conditions; and what to do when someone needs follow-up after surgery or after seeing a specialist. We all know those conversations that say ‘follow-up with your GP in two weeks’. Doing a PGPPP gives you a chance to experience what it’s like when a patient comes to you and you have minimal information on what has occurred (it also makes you complete better discharge summaries and know the relevant information to give to the GPs).

Abby’s top three tips for someone doing their PGPPP:

1. Be enthusiastic – the keener you are to learn and throw yourself in the deep end, the more you will get out of your time doing a PGPPP rotation.

2. Don’t be afraid to ask questions – this is a unique area of medicine where you are expected to have a huge knowledge base and the only way to build this is to ask for help or suggestions on ways to manage things better.

3. Enjoy your time off – there’s something to be said about working regular hours and maybe even only working four days a week (like me). You can learn to feel like a fully functional human again!

Taking a fresh look at general practice
Taking a fresh look at general practice

You can hear the joy in Stephanie's voice as she recalls working with her grandfather and also her grandmother, who was the practice nurse at the Gordonvale clinic. "They used to pay me $4 an hour," she tells Going Places magazine. "And for lunch they bought me cream buns from the bakery across the road!"

"I worked on reception, greeting patients and asking them for their Medicare cards," Stephanie recalls. "My grandfather told me the best thing I could do was to remember a patient's face, greet them with their name – I always used 'Mrs' or 'Mr' – and to be their friend."

She says that her grandparents, who both worked at the clinic for about 50 years, emphasised the importance of understanding the different elements of a patient's life as well as their medical condition. "My grandfather helped his patients in other parts of their lives," she says. "He explained how he helped one patient, who was an alcoholic, to manage his finances so that he would have enough to live on.

This rounded approach to medicine appealed to Stephanie, but it was a placement during her medical degree at James Cook University in Townsville that helped confirm her choice. "When I first started studying, I thought that maybe I wanted to be a paediatrician," she says. "But the more I was exposed to general practice, the more I wanted to do it. We had a clinical elective in our final year of medicine and I chose to do eight weeks of general practice and it gave me a great feel for it."

During this placement she saw her own patients for the first time. "It was scary seeing my first patients, but they were very kind and prepared to answer all of my silly questions!"

The experience also allowed her to explore her interest in paediatrics. "It was so hands-on. I got to do a lot of baby checks and immunisations. It felt so good to help instead of just sitting in the corner."

Stephanie completed the first year of her internship at Cairns Base Hospital in 2011. She and her husband Glen, then moved to Mackay in 2012 where she did her junior house officer year at Mackay Base Hospital.

Stephanie had already enrolled in GP training when she found out she had secured a spot on the Prevocational General Practice Placements Program (PGPPP) for a 12-week placement at Awal Medical Centre in Sarina, about an hour south of Mackay.

"The PGPP program was a life changing experience and it should be a compulsory part of all training."

Ayesha Richardson, NTGPE program participant

Embrace a new experience

Immerse yourself in the Northern Territory through our Prevocational General Practice Placement Program.

For further information contact education@ntgpe.org.au or call 08 8946 7015 www.ntgpe.org.au

Ayesha Richardson at Goulbourn Island Coast camp site with a turtle shell from dinner the previous night.

A lifetime of learning

Dr Stephanie Barnard got her first taste of general practice as a 10-year-old helping at her grandparent’s clinic in Gordonvale, a small suburb south of Cairns in North Queensland. It was here that her GP grandfather taught her valuable lessons in patient care that she still carries with her today.

"My grandfather helped his patients in other parts of their lives," she says. "He explained how he helped one patient, who was an alcoholic, to manage his finances so that he would have enough to live on."

This rounded approach to medicine appealed to Stephanie, but it was a placement during her medical degree at James Cook University in Townsville that helped confirm her choice. "When I first started studying, I thought that maybe I wanted to be a paediatrician," she says. "But the more I was exposed to general practice, the more I wanted to do it. We had a clinical elective in our final year of medicine and I chose to do eight weeks of general practice and it gave me a great feel for it."

During this placement she saw her own patients for the first time. "It was scary seeing my first patients, but they were very kind and prepared to answer all of my silly questions!"

The experience also allowed her to explore her interest in paediatrics. "It was so hands-on. I got to do a lot of baby checks and immunisations. It felt so good to help instead of just sitting in the corner."

Stephanie completed the first year of her internship at Cairns Base Hospital in 2011. She and her husband Glen, then moved to Mackay in 2012 where she did her junior house officer year at Mackay Base Hospital.

Stephanie had already enrolled in GP training when she found out she had secured a spot on the Prevocational General Practice Placements Program (PGPPP) for a 12-week placement at Awal Medical Centre in Sarina, about an hour south of Mackay.

"The more I got exposed to general practice, the more I wanted to do it."
"When I first got told I was doing my PGPPP, I had already got into GP training. So, at the time I thought it was a bit silly for me to do the program and that I should be getting more exposure to the hospital system."

“But it was fantastic,” Stephanie says. “I got my own patients, my own room and my own computer. Some days I saw up to 30 patients and had regular ones who I would check up on.

“I did referrals to the hospital, so I was suddenly on the other side of the coin. I saw how difficult it could be for GPs to contact specialists at the hospital to ask questions or just to let them know that they are sending a patient to them.”

Stephanie is now a principal house officer at Mackay Base Hospital where she is doing a six-month paediatric rotation. To build on her interest in paediatrics and women’s health, she is studying a Diploma of Child Health through Westmead Hospital in Sydney and passed her exams for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Diploma this year.

It has been a busy few years for the 26-year-old. She and Glen married last year. The couple, who relax by waterskiing at the nearby Kinchant Dam, would one day like to start a family.

For now, they are content with their beloved Golden Labrador “puppy” called Bailey. “She sat in the front pew at our wedding!”

In August, Stephanie will start work at the Canelands Medicine Centre, a practice with about eight doctors. “I just want to get out into GP land!”

She likes that GPs are the first point-of-contact for a lot of non-medical matters. “I think just being able to communicate with patients and getting to know them and also their special circumstances and their families is really important.”

“GPs are someone for the community to come and see if they are unwell but also if they need help in other parts of their life – if they are struggling financially, have gambling or marriage problems.”

During her time in the hospital setting, Stephanie has been a passionate GP Ambassador for the Going Places Network. So, what does she tell junior doctors about general practice?

“Telling them how great the money is! They don’t realise that it can compare to specialist training,” she adds. “I also tell them that you can choose the lifestyle you want, how you can work part-time and spend time with your kids.

“You can also follow any medical interests you have. I have an interest in kids and women’s health and, to a degree, you can select your patients to align with your interests. If you really like a certain type of patient then you will enjoy treating them and they will enjoy being treated by you and become a regular.”

Stephanie, who is following the RACGP pathway, is excited about both the personal and professional options ahead of her.

“I want to have kids and be part of a practice. Eventually, I want to be able to run my own practice in a similar set up to my grandfather.”

Sadly, her grandparents have both now passed away and won’t be able to see her come full circle – from the girl who worked on reception and ate cream buns to the young woman who may one day have her own practice and family.

However, their advice and the fond memories of her very first GP experience will stay with her as she moves forward with her own patients, and on her own journey.

Written by Laura McGeoch

“Perhaps, the practice that owns it, is welcoming of registrars; we have a great clinical mix from emergencies to chronic care, and we appreciate the chance to help to educate the next generation of GPs.”

Dr Mark Overton - Registrar Supervisor, Narrengate Medical & Dental Centre

- Flexible hours
- Practices located across Australia
- Experienced GP Supervisors
- Access to a broad mix of clinical cases
- Medical centres that incorporate onsite radiology, pathology, specialists and allied health providers

To learn more about practicing from one of our medical centres, please contact
Dr Sanjay Nijawan (MBBS, FRACGP, FAChPrim, DipDerm(Wests), Conjoint Lecturer UNSW)
Ph: 0488 137 052 or via email sanjay@nijawan@primaryhealthcare.com.au

Primary Health Care Limited
Level 5, 359 George Street, Rockhampton QLD 4700
www.accomprimaryhealthcare.com.au

Affordable and Accessible Health Care

During her PGPPP at Awal Medical Centre

Learning how to take blood with her grandpa

Medical Observer on iPad

“I love the MO iPad app. It is sleek, simple, portable, informative, up to date and educational. All in my hand wherever I need it.”

– Dr Jane Ramsey, GP, Woodside, SA

Download MO for iPad from the Apple App store

iPadWinnersHPH-ARTWORK.indd   1
0x0 31/07/13   9:21 AM

Dr Jane Ramsey, GP, Woodside, SA
Taking a fresh look at general practice

A story to tell

Inspired by his father’s stories about life on the land and with a knack for ‘fixing’ things, Dr Guy Sanson left school at 16 to work on his family’s farm. Little did he know that, nearly three decades later, he would be working in a general practice clinic and helping to repair his patients’ health by listening to their stories.

As a country boy growing up in the central New South Wales town of Lake Cargelligo, a population of around 1500, Guy Sanson, did what country boys do best—play sport.

“When I was a small town we had some pretty winning teams at times,” says Guy of his sporting days. “Often you’d find yourself lining up for the town’s Aussie rules Tigers on Saturday and then for the Sharr’s rugby league team on the Sunday.”

There was sport, there was the farm and there was school. “I was always a good student, but I just got to a certain point and decided that I wanted to be a farmer,” says Guy. In his Grade 11, he came across Going Places magazine.

In 1985, Guy finished year 10 and started his first stint on the family’s farm, run by his father and three uncles. It was a decision that Guy’s father, who just wanted his son to find his own way, neither encouraged nor discouraged. The farm was a broad-acre dry land farm that grew winter cereals of wheat, barley and oats and also had a diverse livestock of cattle, pigs and sheep.

After about a year, Guy left to do an apprenticeship and returned four years later as a qualified mechanic. But while he loved certain times, “I decided I just wanted to do something different,” he explains.

Wanting to study something that related to his love of sport, Guy set his sights on physiotherapy. He enrolled in a tertiary preparation course, which he says was an excellent alternative to going back to high school. The possibility that he could actually aim even higher than physiotherapy was first raised by the “passionate” TAFE teachers who were preparing him for university. They pointed out that the grading system used at the time could be unfavourable to students in small high schools. However, TAFE and away from the school setting, Guy would only be limited by his own ability or willingness to work hard.

So Guy worked hard and, combined with an aptitude for study, he excelled. His ambition grew as he considered the new possibilities that were now within his reach. “The combination of doing well in the TAFE course, the idea that maybe I was ‘smart enough’ to do something like medicine, being an avid RFU watcher and wanting to achieve something significant, all helped to plant the seed to try for medicine.”

“Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. “Part of it was just achievement for achievement sake,” he admits. 

"That's one of the good things about general practice," he says. "If you have an interest in something, you can pursue it and practice a lot of different things up to whatever level you feel comfortable.”

As such, Guy has completed a year-long advanced skills post in anaesthetics and six months in an intensive care unit, both at Nowra’s Shoalhaven District Memorial Hospital.

Wishing to follow the rural pathway, Guy and his physiotherapist partner Susan, with whom he has two young daughters – Ruby, four and Esther two – moved to Susan’s hometown of Griffith in southwest NSW. In July 2010, he started his registrar training at Kookora Surgery and also completed some training at Griffith’s Your Health surgery. In preparation for his exams, he started working part-time and now works three days a week at Kookora and one day at Griffith Base Hospital in anaesthetics.

He is enjoying building relationships with his regular patients and making a positive contribution to their health by getting to know them and their lives. “You come to realise that we are in a very privileged position to be able to have a little peek into all of these people’s lives,” he says. “They surprise you all the time.”

He recalls one older lady who would come to him with a myriad of complex medical complaints. “For about two years I was brushing my head trying to work out her medical problems,” he says. “Then one day she told me a tragic story that had happened to her family many years ago. ‘In one fell swoop I sort of forgave her for every headache she’d caused me and realised that she needed and was very deserving of my time. ‘At the start, I was so focused on getting the medical side of things right, but sometimes all you need to do is just sit and listen to the patient’.

Does he miss life on the land? “My father and I used to spend a lot of time together, going around fixing things on the farm. I do miss that,” he says. “I remember when I was growing up that I always loved the stories that my dad and my uncles used to tell about the farm. ‘To a certain extent, that’s also the part I find most rewarding about general practice – finding out a patient’s story. Everyone has one.”

Now it’s Guy who has an interesting story to tell his daughters about the road from the farm to general practice. “Certainly reflecting about all I’ve done since my decision to leave the farm gives me a great sense of achievement,” says Guy. “People often comment that I’ve had an unusual and remarkable journey.”

Written by Laura McGech
Photos courtesy of Justin Sanson

Scholarship, receiving financial assistance in return for a six-year commitment to working in a rural area. Guy did his internship at Wollongong Hospital, but wasn’t tempted by the other specialties. During university he went on a John Flynn Scholarship in Derby WA, and was exposed to the variety that general practice offers. “It was in Derby where I discovered that GPs could do anaesthetics and so I decided I might try that.”

“‘That’s one of the good things about general practice’,” he says. “If you have an interest in something, you can pursue it and practice a lot of different things up to whatever level you feel comfortable.”

He started physiotherapy at the University of Sydney. After one year, he decided to go for brake and become a doctor. Specialising in general practice was always his intention. “Growing up in a smaller town, you are aware that a doctor holds a special place in that community.”

Guy secured a place in medicine at the University of New South Wales through the Rural Entry Scheme, which set aside places for people from rural backgrounds. This scheme, Guy says, gave him a wonderful chance that he wouldn’t have otherwise had.

So, aged 32 and 16 years after leaving high school, Guy became a medical student. He began in 2001 and went through on a bonded working towards;” he adds. “It was also sort of like having four different bosses and each one having their own ideas.”

He took a break from the farm and began to consider going to university as a mature-aged student. At 28, and 12 years since leaving high school, Guy was excited for the chance to seize a new lease on life. “I decided I just wanted to do something different,” he explains.

He is enjoying building relationships with his regular patients and helping to repair his patients’ health by listening to their stories.

REGISTRAR PROFILE

You come to realise that we are in a very privileged position to be able to have a little peek into all of these people’s lives.”
A rural career takes off

Rural-remote GPs are known for their wide-ranging skills. Registrar Dr Gerry Considine has similar diverse interests after hours as a pilot, blogger, rocker and a fairly ordinary footy player.

When Dr Gerry Considine was thinking of moving to a speck-on-the-map town in South Australia to further his GP training, one thing clinched the deal.

The GP who was to be his supervisor owned two planes. As someone with a longstanding ambition to learn how to fly, Gerry’s mind was made up. Wudinna it was.

Since then, he has earned his recreational pilot’s certificate – and thrown himself into work and community life. Playing on the wing for the Wudinna B-grade footy team is a weekend ritual.

“After playing footy one day, I was asked to stitch up a lip and take an X-ray from the game I had just been in,” he recalls. “Luckily, they weren’t a result of my rough play,” he says, with a grin. “If that happened and continued, I’m sure Medicare would have asked some questions.”

Gerry’s mind was made up. Wudinna it was.

As someone with a longstanding ambition to learn how to fly, Gerry was inspired to study medicine by his grandfather, an ear, nose and throat specialist. “He has a real sense of humanity and doing something for others,” Gerry says. “During my medical training, I had two very positive experiences in rural general practice. These cemented my plans not only to do GP training but to head bush with it.”

Gerry is currently working towards both GP college fellowships, and has recently completed a Diploma in Child Health.

His obsession with flying continues; he is working towards getting his private pilot’s licence which may come in handy to get around the country as a GP in the future.

Other extracurricular activities include playing in an indie rock band called Stomp the Orange. He has also embraced the digital world and he blogs and tweets on everything from learning to fly to medical policy issues and a miscellany of life’s little absurdities.

You can visit Gerry’s blog at ruralflyingdoc.com

What you can earn

The earning power of GP registrars and GPs is excellent when you consider the flexibility and work-life balance of the profession.

GP registrars

Full-time GP registrars work a minimum of 38 hours a week. This includes education time and administration time. The actual hours of consulting (seeing patients) are usually between 27 and 33 hours per week. This can vary, especially in rural areas.

Registrars can choose a set salary model or negotiate a percentage of income generated by the patients they see in the practice. In this case, remuneration is determined by how many patients are seen and whether there is bulk-billing or private billing.

Minimum terms and conditions

During the first two GP terms (or ACRRM equivalent), GP registrars are guaranteed minimum terms and conditions of employment according to the National Minimum Terms and Conditions (NMTC) document agreed by GIPRA and the National General Practice Supervisors’ Association. Minimum salary rates are set out in the table below, or alternatively the registrar is paid a minimum of 45% of gross billings, whichever is greater.

2013 training year minimum salaries, plus 9% superannuation

<table>
<thead>
<tr>
<th>Training stage</th>
<th>Location</th>
<th>Practice style % of billings paid</th>
<th>On-call</th>
<th>Average patient consultations (hours/week)</th>
<th>Weekly*($)</th>
<th>Annual*($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP term 1 registrar</td>
<td>Any</td>
<td>45%</td>
<td>N/A</td>
<td>4 patients per hour – 28 hours per week</td>
<td>$2,307</td>
<td>$120,000</td>
</tr>
<tr>
<td>GP term 2 registrar</td>
<td>Remote</td>
<td>50% mix billing,hospital admitting rights,procedural work (anaesthetics)</td>
<td>1 in 2-3 days</td>
<td>60 hours</td>
<td>$3,007</td>
<td>$160,000</td>
</tr>
<tr>
<td>GP term 3 registrar</td>
<td>Rural</td>
<td>60% mix billing,hospital admitting rights,procedural work (anaesthetics)</td>
<td>1 in 6 days</td>
<td>28-30 hours</td>
<td>$2,788</td>
<td>$145,000</td>
</tr>
</tbody>
</table>

On-call and hospital VMO work earn GP registrars a minimum of 55% of the hospital billings.

Different remuneration systems

It is important to note that working in rural areas, doing procedural work and working as a hospital VMO tend to attract significantly higher incomes. However, even in urban areas GP registrars often earn more than what is stipulated in the NMTC document.

For GP registrars and GPs practising in rural areas and identified areas of need incentive payments are available on top of a regular salary.

Established GPs

Established GPs can earn good money with the actual amount dependent on the nature of the practice and hours worked. In addition, there is the opportunity to run your own medical practice if you choose – all this with flexible hours and choice of practice style.

* After playing footy one day, I was asked to stitch up a lip and take an X-ray from the game I had just been in.
Is general practice the specialty you have been looking for?

Join the Going Places Network today and find out more about general practice.

- More than 2,300 junior doctors have already joined us
- Network with experienced GPs and meet other peers interested in becoming a GP
- Attend free networking and educational lunches and dinners
- Access free tools and resources
- Get key information from your local GP Ambassador in your hospital

First day survival tips

In your room

- Open all the cupboards to find out where everything is.
- Locate where all the prescription, pathology and radiology forms are kept, and check with reception staff where the extra or infrequently used referrals and forms are kept.
- Work out which way the paper faces in the computer printer.
- Work out how to use the phone. Put labels against internal numbers if not already done.
- Check if there is an emergency alert button, and how to use it and turn it off.
- Explore where common equipment is kept:
  - What type of sphygmomanometer, which way the BP cuff faces and where the large cuff is kept
  - What type of thermometer, and where the otoscope with different-sized specula for ears and noses is kept
  - What type of specula and which sizes are kept, in addition to other Pap smear equipment
  - Different types of swabs (M/C/S, PCR) and specimen jars.
- Put resource books in your room.

If available

- Locate Therapeutic Guidelines, either print copies or on the desktop of your computer.
- Add useful and recommended websites to your favourites or bookmarks list on your browser.
- Play with software. Use a fake patient to manage a condition. Every practice will have one of these on their system for you to experiment on.
- Locate where information leaflets are on the toolbar (especially Medical Director).
- Start collecting resources that will be useful during your consulting, such as guidelines for bowel screening and a flowchart for investigating breast lumps. Keep them in an accessible place, such as a folder or file.

In the practice

- Check out the treatment room, especially where dressings, vaccines and needles are kept. Does the practice nurse administer vaccines?
- Check how to fill up and use liquid nitrogen for cryotherapy.
- Find where the resuscitation kit and oxygen are kept. Ensure you know what is in the kit and how to use it. Also find out if you have access to oxygen saturation monitors and an ECG.
- Make friends with the practice staff — they can make your life much easier. Be friendly and polite, and make an effort to learn their names. The practice manager is a key ally and can help smooth your way into your new environment — and they know lots about Medicare!
- If you have a practice nurse, get to know them well. They can be very helpful and a valuable resource.
- Have a say in setting up your bookings. You will almost certainly need extra time until you find your feet, so book accordingly (ideally two patients per hour when you first start, moving to three or four when you feel comfortable). Let the practice staff know the common procedures you may routinely need extra time for (eg. Pap smears, psychological intervention and care plans, skin excisions).
With your supervisor

- Check the practice booking and billing system.
- Ask about the practice policy on checking and follow-up of results and patient recalls, including who follows up your patients’ results after you leave the practice.
- Establish their preferred method of being contacted for questions during consultations (eg. phone, knock on the door; internal messaging system) and after hours. If you are doing after hours cover, make sure that a senior has been designated to back you up and that you have their contact numbers.
- Ask for a list of local services:
  - pathology/radiology
  - allied health
  - specialists
  - the capabilities and specialist coverage of the local hospital
  - community or domiciliary nursing services
  - local audiometrists and optometrists.
- Talk about your teaching requirements. Make sure you have sufficient designated teaching time and discuss how you would like to use this.

During consultations

- Take a deep breath, count to 10 and then call your first patient in.
- Start with open-ended questions.
- Try to get the full list of the patient’s complaints and needs early in the consultation. Then you can prioritise and, if required, book a second appointment to cover the list in full.
- Try to do all the work for each consult (investigation requests, prescriptions, referrals and notes) during the consultation to avoid having to hang around after hours when everyone else has gone home and when you are more likely to forget the details.
- Have a system for keeping track of clinical questions that arise during consults (eg. notebook on your desk, manila folder with patient consult summary printed) to ask your supervisor or look up.

PES scripts

- When prescribing an item, check to see if there are any restrictions on indications for therapeutic use. If you are using the medication for a different indication, write a private script for the item.
- Maximum quantities and repeats listed are calculated to provide a one-month supply per dispensing amount, and enough repeats for a six-month supply of the usual recommended dose. If the patient requires less than the maximum quantity, it may be sensible to prescribe less. If the patient requires more than the usual recommended dose, and thus would not get a one-month supply per dispensing/six months per script, then seek an Authority script for increased quantities.

Authority scripts 1800 888 333

- Become familiar with the indications for the Authority medications you commonly prescribe. Have the required information ready when calling the Authority prescription number to avoid delays.
- You can use Authority scripts to prescribe increased quantities of PBS/PPBS medications if you are using doses that are higher or courses that are longer than standard. However, be sure you are still prescribing appropriately and safely.

S8 drugs of addiction

- Special circumstances apply to the prescription of S8 drugs of addiction. You need to comply with PBS requirements (outlined in the Yellow Book), but you also need to comply with your state legislation. Find out what these requirements are, and make sure you comply with them.
- Talk with your supervisor or practice manager about prescribing S8 drugs, and any practice policies they may have. For example, no prescribing of S8 drugs to new patients at first appointment, or no prescribing of S8 drugs on weekends.

Private scripts

- Pharmaceutical items are included on the PBS on the basis of efficacy and cost-effectiveness. There will be instances where you feel a product is clinically indicated, but your patient does not meet criteria for a PBS script. For example, reduced bone density but no fractures, but you feel a bisphosphonate is appropriate; or elevated cholesterol but outside the criteria for a statin. You should still recommend the appropriate treatment for your patient, but explain to them that they cannot access subsidised medication for this condition and will need to pay more for a private script if they go ahead with treatment. Many private health funds will reimburse for these medications.

Prescribing for travellers

- Patients traveling overseas will need to have sufficient quantities of their medications prescribed and dispensed for the length of their trip.
- Provide patients with a letter outlining the medications they will be taking — most medical records software will have a template for this.
- There are special rules for taking PBS-subsidised medications out of Australia. They must only be for the personal use of the traveller or someone travelling with them, and quantities may be restricted. However, these restrictions do not apply to private (non-PBS) scripts. Patients should always ensure their medications are legal in the countries to which they are travelling.
- Regulation 24 allows the original and repeat supplies to be dispensed all at once, and you may need to endorse the traveller’s script with Regulation 24 to allow the pharmacist to dispense sufficient medication for their travels. You can find information on Regulation 24 in the explanatory notes of The Yellow Book or at pbs.gov.au.

More information?

- Medicare Australia face-to-face sessions or online tutorial: medicareaustralia.gov.au/provider/business/education/e-learning.jsp.
- Talk to your supervisor.
- Talk to your local pharmacist.
Which hospital are you based at?
Joondalup Health Campus in Western Australia.

What are you looking forward to most as a GP?
Building close relationships with patients and their families and providing continuity of care.

Why did you choose general practice?
I want medicine to be a part of my life, not my entire life.

Who inspires you?
My mum. If I am half the mum she is one day I’ll be doing a great job.

Which three words best describe you?
Efficient, friendly, approachable.

What three things would you take to a deserted island?
My bible, a fishing rod, a boat.

Which cartoon character are you most like?
Patrick the starfish from SpongeBob SquarePants.

NSW/ACT update
Our Ambassador workshop armed everyone with the most up-to-date information surrounding the application process, and all Ambassadors reported being busy answering questions from their cohort in the lead up to and during the application period of April/May. An Ambassador or the state coordinator attended most of the AGPT hospital sessions in NSW and the ACT. These sessions gave us a good feeling for just how much interest there is in general practice in the preclinical sphere. Thanks to our ACT Ambassador, Kristen McMahon, who got the ball rolling and arranged the first ever session at the Canberra Hospital, which was well attended. Keep an eye on our website for details of upcoming events in NSW/ACT for the remainder of the year.

SA update
On 25 February, the SA Network held a dermatology workshop and dinner event at the Osmond Terrace Function Centre in Norwood. The evening provided a fabulous opportunity for attendees to refresh and update their dermatology knowledge whilst socialising with a great bunch of like-minded doctors. The GP presenters, Dr Penny Need (Adelaide to Outback GP Training) and Dr Paul Molyneux (Sturt Flinders GP Training), both gave excellent and engaging talks. The pop quiz and Easter eggs were especially popular!

QLD update
SouthEast Queensland Network members were treated to an evening with inspiring GPs, Danielle Araraba, Zach Tappenden and Scott Kitchener – and the inimitable Professor John Murtagh. Danielle shared her insightful experiences with Aboriginal and Torres Strait Islander patients in Brisbane. Zach inspired junior doctors about the endless career possibilities the rural generalist GP has in North Queensland, and Scott covered interesting cases of rural farming patient presentations. The main speaker for the night, Prof. John Murtagh, covered a lifetime of general practice experiences and highlighted how general practice had grown and changed over time. He revealed that the reason he knows so much is because he recorded many of his experiences as they occurred, and shared a number of cases that challenged him over the years. If you’re looking to be the next Prof. Murtagh – start recording and updating your cases with patients now!

A big thank you goes to the GP Ambassadors of the evening who presented with such finesse: Dr Paul Adams (Toowoomba Hospital) and Dr Louise Knapp (Gold Coast Hospital).

VIC update
In the past 6 months, the Victoria Network has participated in hospital orientations and sponsored events including the Junior Medical Staff Career Expo at Monash Health. Dr Kate Eson, our Ambassador at Southern Health, did a fantastic job at the GPN stand fielding the numerous enquiries about general practice.

In the coming 6 months, our members can look forward to a range of events including the annual networking dinners held in Shepparton, Geelong, Ballarat and Melbourne. We look forward to providing you with a diverse range of speakers and topics at these events.

TAS update
What an action packed 6 months it has been in Tasmania! In February we kicked off the year with a networking dinner in Hobart, followed by a June dinner event in Launceston. Students and junior doctors flocked in droves to the first GPN event in Launceston held at the PA Taps restaurant.

Three very inspirational speakers: Dr Natasha Varnek, Dr Tim Flannagan and Dr Nick Stacey, touched on the variety a general practice career can offer, and spent the night networking with the students and junior doctors.

It was a fantastic event, with some positive information sharing between the students and junior doctors.

WA update
Around 60 eager applicants joined GPN and WAGPET for the AGPT Selection Preparation Sundowner. The event offered insight into the assessment process and GP training ahead of the National Assessment Centre in June.

The evening began with an informative presentation by WAGPET Medical Educator, Dr Murray Nixen, who took attendees through the National Assessment Centre process. Also covered was the Regional Training Provider selection, placement offers and new registrar induction day.

Dr Michael Kurian spoke about his positive experiences of the program and assured attendees that despite the stress they may be feeling now about their upcoming interviews, once they get into training, they will find themselves in an exciting and rewarding career.

Taking a fresh look at general practice

Now available for iPad

Every month MedicineToday for iPad will deliver the full contents of the print edition that you know and trust: in-depth clinical reviews, regular features, news and journal grabs, all written by experts and fully peer reviewed.

Get the free app and use the log in details you created for the MedicineToday website to sign in and enjoy your usual experience on your iPad.

Apple, the Apple logo and iPad are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc.
Your GP Ambassador Network

Want to get involved
Going Places Ambassadors are junior doctors who have a real passion for general practice.
To find out more about becoming a GP Ambassador, email goingplaces@gpra.org.au

It takes 2

Melissa:
It took me a while to decide what I wanted to do in medicine. I spent some time travelling and doing locum work after my intern year before returning to the traditional hospital training pathway. I enjoyed emergency medicine, but in the end, the shiftwork meant there was too much time spent away from home. It was my partner Tom who suggested that I would like working as a GP because I’d enjoy getting to know my patients and really exploring where they were coming from. That suggestion changed my career trajectory and I’m much happier for it. Part of what I enjoy about general practice is that it allows you to utilise all of your life experiences and the more diverse your pathway has been, the more experiences you have to draw upon in your clinical practice.

I saw the role with AFP as an opportunity to become involved in the ‘bigger picture’ of general practice in Australia. I find it exciting to be involved in improving everyday general practice and patient outcomes through working with authors, reviewers and the excellent AFP team. My role with AFP also complements my work as a GP registrar at the Family Medical Centre in Sunbury, as it provides the opportunity to keep up-to-date with the latest evidence, guidelines and ideas relevant to general practice.

Because AFP is a very practical journal, the manuscripts that pass through my hands often contain information that directly informs my patient care. The process of medical editing also reinforces the basic importance of evaluating the information that lands on your desk. Carolyn is extremely considerate, conscientious and balanced in her approach as a supervisor. Since I’ve joined GP training, I’ve been fortunate to learn a great deal of down to earth wisdom from some very inspiring GPs. Carolyn is one of the best in my eyes.

What I admire about Carolyn is that she is honest, good-humoured and unpretentious. She always seems to swim where others might sink easily, and somehow she manages it with great grace too. I remember Carolyn once said that every profession has its booby traps and that expertise can only be built upon experience. I think comments like these give a good picture of how Carolyn operates, in that she has a great deal of practical wisdom based upon astute observations. She has this fantastic ability to articulate complicated concepts in simple but precise terms. I’d love to know how she does that.

I think that one of the most important roles of a GP is to provide an open space for people to speak without fear of judgement. My aim is to become a knowledgeable and perceptive GP with a few good tricks up my sleeve – someone who I would be happy to look after my mum!

Carolyn:
I was not one of those people who entered medicine knowing my pathway. I had done work experience in a sports medicine clinic and had found it interesting, but found the diversity of what the doctors did the most appealing. While at university I enjoyed the placements I had in general practice, where the practices were friendly, the patients interesting and the GPs loved their jobs. I felt I was training probably general practice, but then also enjoyed most of my hospital rotations. All this reinforced that I wanted a bit of everything – so general practice seemed the obvious career path to take.

I went into medical education after a friend told me about the academic registrar posts and said it sounded written for me. I particularly enjoyed the teaching element of the role and moved into predominantly education roles. I also think that while I find it fun, it also important to help people learn and become an independent professional. Being a supervisor for GP registrars with AFP is a relatively new and good experience for me.

Melissa is quiet, determined, resourceful, thoughtful and thorough. I admire the way she approaches problems, analyses the situation and then comes up with solutions.

My work as a medical editor complements my clinical work and as a GP I understand how it allows me to keep learning and thinking, and to have some parts of my professional life that work towards helping the profession grow and advance.

At the end of the week, the thing I’m most satisfied about is usually patient related – it being finding a management plan that finally works; measuring a patient over something that was causing them undue worry or using the pieces of information built up over the years to really understand why that patient was presenting with this concern.

The biggest career benefits of general practice is the variety of medicine and the ability to use your skills in different ways. From taking a fresh look at general practice
As a born and bred city girl, working flexible hours in a busy clinic in the heart of Melbourne is exactly where mum and GP Dr Sarah Matenson wants to be.

If Dr Sarah Matenson’s job was advertised, it would tick all the boxes that a good job should: flexible work hours. Tick. Ability to specialise. Tick. Autonomy and teamwork. Tick. Good local coffee. Tick! And the list would go on.

It’s no surprise then, that after 11 years at Mid-Town Medical Clinic on Melbourne’s Collins Street, Sarah has no plans to leave any time soon.

“I’m very privileged where I work,” Sarah, who lives in nearby Port Melbourne, tells Going Places magazine. “I even get to ride my bike to work – that’s part of the beauty of it.”

Sarah dismisses the perception that a city GP’s patient list is full of grumpy office workers with coughs and colds. “I don’t tend to do a lot of that ‘non-interesting’ general practice here,” she says of Mid-Town, which has about 15 GPs.

“It’s like a mini hospital. We have a sports clinic with a physiotherapist and allied health professionals attached to our centre, as well as orthopedic and skin specialists,” she explains.

“There’s a real ‘team’ feel here. We ask each other questions and are very collaborative.”

As part of her registrar training, Sarah did two city-based rotations, including one where she now works, and also spent six months in the picturesque town of Daylesford, north-west of Melbourne.

As part of her registrar training, Sarah did two city-based rotations, including one where she now works, and also spent six months in the picturesque town of Daylesford, north-west of Melbourne.

“I enjoyed my country work, but there are two main reasons including one where she now works, and also spent six months in the picturesque town of Daylesford, north-west of Melbourne.

On the downside, Sarah admits that city-based GPs practise less acute emergency medicine, which was an area she enjoyed during her internship in Bairnsdale in regional Victoria and at an outer suburban Melbourne hospital. Her introduction to the emergency department was a baptism of fire, of sorts, but Sarah “loved” the work and met the challenge head on. “My first ever shift as a doctor lasted 30 hours and included running the emergency department overnight. That was a bit scary!” she recalls.

But while she may not see as many acute injuries as her rural counterparts would, her patient list is still varied. “I remember, not long after I started, having a medical student sit in with me. I told them that some days can be quite routine, but then we immediately had a succession of really diverse medicine – there was one patient with breast cancer, we did an initial MS diagnosis and there was a case of appendicitis.”

Sarah did her Diploma of Obstetrics during her registrar training and now provides shared care for pregnant women who want to split their appointments between their GP and hospital midwife or doctor. She says it’s a great option for women working in the city and suitable for low-risk pregnancies. “Most of the patients I see for shared care are already my patients to start with,” she says. “That’s the advantage – you already have a relationship with them. You get that continuity.”

It was a combination of medical and personal elements that attracted Sarah to obstetrics and gynaecology. “On the whole, it’s a well and happy medicine,” she says. “People aren’t usually coming to you with diseases or illness. I’ve been around my fair share of tricky labours, but mainly this work is fairly upbeat and happy.”

“I like how defined obs and gynaec is,” she says. “Most of the time, it is anatomically straightforward medicine – a uterus and two ovaries. I don’t want to over-simplify it, but I see a beauty in that. There is a good sense of control,” she adds.

“Ticking all the boxes that a good job should have as a city GP...”

Taking a fresh look at general practice

The theme of stripping medicine back to basics first touched Sarah when she worked in a children’s hospital in Nepal as a medical student. “I just realised that the most life-saving kind of medicine that we could do for most people there was basic medicine and sanitation. We saw so many vaccine-preventable diseases that we just don’t see in Australia.”

In terms of the local landscape, Sarah says Australians are becoming more informed about their health. “I’m seeing far less colds and trivial things,” she says. “People are better educated about their health. They come in for preventive screening now, which is unheard of in a lot of countries.”

“I also see more mental health issues now than when I first started. I don’t think that’s because there is more prevalence, I think people are just more comfortable to talk about it and to address it. They might have previously gone straight to a psychologist, but now they go to their GP first!”

“As part of my registrar training, Sarah did two city-based rotations, including one where she now works, and also spent six months in the picturesque town of Daylesford, north-west of Melbourne.”

“... the thing about general practice is that I’m my own boss. Now and then there will be an emergency that will make me run late, but generally I can get out on time.”

“I’m using my city training to its full capacity. My GP colleagues are a great team to support me.”

This trust and continuity of care that GPs develop with their patients is what appeals to Sarah. “It’s lovely when you start to establish that long-term relationship with patients … when they come back and see you, or send you a letter or a card to say ‘thank you!’”

Sarah, who has two sons – Angus, seven and Tommy, four – lists the flexibility she enjoys in her city clinic as another major benefit of general practice. “That’s why I love it,” she says. “I am working four days a week now, but whatever I want to do is fine [with the practice]. Everyone here has a very balanced lifestyle.”

“I’m usually seeing my first patients by 9:30 am and on some days finish at 3:00 pm so I can manage the school and kinder runs a couple of times a week.”

“It can be really draining for a GP to work five-days a week – it’s a constant revolving door of people. So it’s important that you have time to try out other medical or personal interests.”

And while she has a great team to support her, Sarah says she “loves” the autonomy of her role. “The thing about general practice is that I’m my own boss. Now and then there will be an emergency that will make me run late, but generally I can get out on time.”

Although traditionally it has been women taking up part-time work, Sarah says male GPs are also now increasingly seeking to better balance their work and personal lives.

“The new generation coming through is more into lifestyle and less into the management side and the stresses that come with it. Years ago, when I first started out, I might have said I want to run my own practice one day,” she says. “But it’s kind of hard to be the business person and the doctor as well.”

So, where does Sarah see herself in 10 years time? Sarah’s reply confirms that her city job is the perfect fit for her. “Probably doing something very similar to what I am now!” she laughs. “Maybe I’ll do a little bit of teaching or simple surgical assisting. There are so many options.”

Written by Laura McGeoch

Taking a fresh look at general practice 27
Walking the rural path

What do dogs have to do with rural doctors?

Professor Tarun Sen Gupta shares his thoughts.

“Get a dog. Every rural GP should have a dog.”

It wasn’t the serious, academic answer Going Places expected when probing a professor for tips on how junior doctors can become good rural GPs.

But Tarun Sen Gupta, Professor of Health Professional Education and Director of Medical Education at James Cook University, is the dog-owning owner of two golden retrievers. And it turns out there are well-considered reasons for his response.

“When I worked in western Queensland, my wife and I had an old one-eyed dog called Andy. When you have a dog, you discover a lot more about the community where you live because you take the dog for a walk every afternoon.

“We got to know the town better, and we saw and got to know the people. And it was good for exercise and stress relief,” he explains.

That’s community engagement, exercise and stress relief in one hairy package.

It’s been over 26 years since Tarun launched his GP career in Richmond in western Queensland, population below 1000. It was to be his mission into a working life funded by a love of rural medicine in Australia’s north — first as a hospital GP then as an educator, researcher and big-picture workforce planner.

Once Tarun starts reminiscing about Richmond, the years fall away and it’s clear that his time there was formative. “You work reasonably hard, you learn a lot about life and I think it was the best job I ever had,” he says. “The people were incredibly warm and welcoming — many of them are still our friends.”

When Tarun arrived in Richmond, he was just 24. Born in India, child in Toowoomba, he had just completed his medical degree and internship in Brisbane when he suddenly found himself the sole doctor in a one-doctor town.

It was something of a baptism of fire — not helped by blazing mid-summer temperatures upwards of 40 degrees, North Queensland. “The hospital power broke down. As the area unfolded, the local cricket team — slightly wobbly after a few post-match beers, stamped around noisily trying to start up the emergency generator.”

Then there was the chihuahua incident — dogs are a recurring theme — when a local vet’s dog was dumped on Tarun’s veranda. Apparently, rural doctors are expected to double as vets.

“Get a dog. Walking your dog will help you fit and reduce stress.”

In 1993, after six satisfying years in Richmond, Tarun and his family moved to Townsville where he combined work as a GP with postgraduate teaching.

“Get a dog. Walking your dog will help you engage with the community while you stay fit and reduce stress.”
Adventure island

Being the resident doctor in an Aboriginal community on the Tiwi Islands is a challenging new adventure for Dr Clinton Leahy—and he's not just surviving but thriving.

“I guess I’m a person who likes adventure in general.”

Dr Clinton Leahy drops words of the Tiwi language into the conversation with his patients, although most Tiwi people “speak pretty handy English” according to Clinton.

Meeting the local Aboriginal people on their own cultural terms is at the heart of Clinton’s approach as resident doctor in Wurrumiyanga, formerly called Nguiu, Wurrumiyanga, which means place of cycads, is a community of around 1,500 people on Bathurst Island in the Tiwi Islands, some 80 km north of Darwin.

Clinton arrived to take up the post a few months ago with his wife Layli and three-year-old son Sunny.

“I’ve been busily spending my time learning the Tiwi language and about the local culture,” Clinton says. “I think it’s important for a doctor to show an interest in the community and a great way to do that is to learn the language.”

He believes that trying to understand the worldview of a community is a key to building trust so that “it’s not just a doctor preaching from the pulpit.”

Clinton’s CV in remote medicine and Indigenous communities is impressive. Most of his training after graduating from medicine at the University of Queensland was in the Queensland outback under the rural generalist program. Here he honed his skills in emergency medicine, anaesthetics and critical care.

Next he worked for more than six years on the Palm Island Aboriginal community near Townsville. Against an idyllic natural island backdrop—not unlike the Tiwi Islands—it was an unforgettable experience of highs and lows.

In 2004, Palm Island became infamous on the nightly news as the scene of Queensland’s most notorious death in custody case, which exploded into a violent aftermath of riots and the torching of the Palm Island police station.

As the doctor of both protagonists—the dead man Cameron Doomadgee and the attending police sergeant Chris Hurley—Clinton found himself a player in a protracted real-life drama of inquests and trials.

“I was a witness in the court and that was an amazing watershed moment in my life,” Clinton recalls. He also appeared in an award-winning documentary about the case, The Tall Man, and was interviewed by Ray Martin on The 7.30 Report about the Palm Island case and the underlying social dysfunction.

The impending arrival of a baby for Clinton and Layli signalled a call out for a more family-friendly setting. Clinton worked for a time in Byron Bay and Nimbin, on the north coast of New South Wales where he grew up. But somehow his medical mojo went missing.

“Certainly Nimbin has a great sense of community and I love the place but I do need a bit more of a challenge,” Clinton reflects.

That challenge came with a move to the Northern Territory, first to Alice Springs and then the Tiwi Islands. “I like the autonomy of working in a smaller centre, using a broad range of skills,” he says.

Clinton’s passion for social justice was a further motivation to return to Indigenous community medicine. “I feel strongly about supporting the underdog and representing people who don’t always have a voice,” he says.

“I guess I’m a person who likes adventure in general. Living in this place is adventurous without the work. But the medicine is also incredibly adventurous and hugely challenging.”

The “incredibly adventurous and hugely challenging” medicine hinges on being a plane trip away from a tertiary hospital. When an acute situation arises—cases are airlifted to Darwin around 300 times a year—Clinton leads the local medical team of nurses and Aboriginal health workers to manage the patient until the CareFlight team arrives. “It’s about problem solving using the limited resources you have,” he says.

Lateral thinking is one of the skills Clinton encourages in the next generation of doctors. As a GP supervisor with Northern Territory General Practice Education (NTGPE), he regularly hosts GP registrars, junior doctors in the Prevocational General Practice Placements Program (PGPPP) and medical students. “When junior people come through they inject the place with a lot of new energy,” he says.

He has observed that many young doctors can feel overwhelmed by the burden of disease and social problems in a remote community like Wurrumiyanga. “But even if they’ve found it difficult they leave so thankful for the experience and a better doctor for it,” Clinton says.

Being marooned on an island has its rewards. On weekends, there’s fishing for barramundi, footy and camping on the beach. And after a day at the clinic, there’s no on-call—the district medical officer always has a voice,” he says.

Supporting the underdog and representing people who don’t always have a voice is Clinton’s passion. “I like the autonomy of working in a smaller centre, using a broad range of skills,” he says.

“I guess I’m a person who likes adventure in general.”
Moving pattern of papillae

Geographic tongue, or benign migratory glossitis, involves loss of the normal tongue surface papillae in the red area, which looks smooth. The surrounding edge looks a grey-white colour, but this varies from patient-to-patient. This case could be mistaken for median rhomboid glossitis, which is a manifestation of candida. However, thrush plays no part in geographic tongue, which gets its name from the moving patterns of papillae loss.

Geographic tongue is linked to vitamin B or zinc deficiency, stress, hormonal factors, diets high in sugar or processed foods, and psoriasis.

For more images, see medicalobserver.com.au/clinical-review/dermatology

Green thumb produces rare disease

About two years ago this patient sustained a penetrating injury from a bougainvillea spike when re-potting plants. The injury healed without incident, but a month or so later a small pustule arose at the injury site. He opened it but only pus came out. Subsequently, the pustules increased in number and his hand became swollen with multiple deep abscesses.

Swabs failed to grow bacteria and there was no response to seven courses of antibiotics! The important additional information here is that he had diabetes and a lung problem, and was on oral steroids and methotrexate. A deep incisional biopsy was done, with half being sent for culture. This grew a fungal organism. The patient had a rare deep fungus infection called phaeohyphomycosis. Treatment was commenced with itraconazole.

For more images, see medicalobserver.com.au/clinical-review/dermatology

Back lesions may be seen late

Patients can often go some time with a lesion on their back before realising there is something there. This is late stage localised morphea, or scleroderma. In the early stage there is a violaceous discolouration of the skin, which then develops a white or pale centre as excess collagen is laid down in the dermis. Later on, the violaceous colour disappears and the white colour is predominant. Later still, a type of post-inflammatory pigmentation appears and ultimately the lesion softens up and pigments all over as the collagen disappears. There is no effective treatment for localised scleroderma.

For more images, see medicalobserver.com.au/clinical-review/dermatology
Primary Health Care Centres

Dr John Houston, GP at Ingleburn Medical Centre and Primary Health Care Chief Clinical Officer

Two of the things I like best about working at Primary Health Care medical centres are the varied cases and the cutting-edge facilities we have here.

I have cases where I’ve managed to have a good clinical outcome within hours.

I start at 6am, and one of my patients, Mrs B, came in. I’ve known her for 14 years. She’s had breast cancer in the past, but it’s been ten years since she was treated.

She came in to have some unrelated forms filled in, but I noticed she has a bit of a cough. She wasn’t unwell, but I listened to her chest and found she had noises in the bottom of her right lung so I referred her for an x-ray.

The x-ray guys started at our medical centre at 7.30am and I got a digital image back from them within seconds. I rang the consultant radiologist, who was able to view the image remotely, and thought it looked a bit patchy.

By 8.30am we had a CT scan done on her, also within seconds. I rang the consultant radiologist, who was able to view the image remotely, and thought it looked a bit patchy.

By 9am I had rung her oncologist and he was able to see her by 10am.

At Primary Health Care medical centres, we see a wide variety of cases, from diabetes management to flu to emergency cases.

A three-week-old baby presented to our medical centre one night recently in respiratory arrest. We managed to resuscitate the baby and stabilise him and I, as lead doctor, was very proud of the efficient way our treatment room nurse handled the situation. The baby was sent on to the local hospital.

The baby was presented to us because it was after hours and their regular doctor was closed.

I was out for a walk with my wife on Mothers’ Day and saw the mother and her very well-looking son and I, as lead doctor, was very proud of the efficient way our treatment room nurse handled the situation.

The baby was referred to the local hospital.

By 9am I had rung her oncologist and he was able to see her by 10am.

She saw me at 6am and within four hours was able to be diagnosed and with her specialist because we have so many services under one roof.

Primary Health Care Dr Stewart Miles – Primary Medical and Dental Centre, Browns Plains

“This centre is very accessible to patients. I have my own patients, even though the centre bulk bills and patients cannot make appointments, they can also choose which doctor they see. But I do see walk-in patients as well.”

At Primary Health Care medical centres, we see a wide variety of cases, from diabetes management to flu to emergency cases.

A three-week-old baby presented to our medical centre one night recently in respiratory arrest. We managed to resuscitate the baby and stabilise him and I, as lead doctor, was very proud of the efficient way our treatment room nurse handled the situation. The baby was referred to the local hospital.

The baby was presented to us because it was after hours and their regular doctor was closed.

I was out for a walk with my wife on Mothers’ Day and saw the mother and her very well-looking son and I, as lead doctor, was very proud of the efficient way our treatment room nurse handled the situation.

The baby was referred to the local hospital.

By 9am I had rung her oncologist and he was able to see her by 10am.

She saw me at 6am and within four hours was able to be diagnosed and with her specialist because we have so many services under one roof.

Primary Health Care Centres

Dr John Houston, GP at Ingleburn Medical Centre and Primary Health Care Chief Clinical Officer

Two of the things I like best about working at Primary Health Care medical centres are the varied cases and the cutting-edge facilities we have here.

I have cases where I’ve managed to have a good clinical outcome within hours.

I start at 6am, and one of my patients, Mrs B, came in. I’ve known her for 14 years. She’s had breast cancer in the past, but it’s been ten years since she was treated.

She came in to have some unrelated forms filled in, but I noticed she has a bit of a cough. She wasn’t unwell, but I listened to her chest and found she had noises in the bottom of her right lung so I referred her for an x-ray.

The x-ray guys started at our medical centre at 7.30am and I got a digital image back from them within seconds. I rang the consultant radiologist, who was able to view the image remotely, and thought it looked a bit patchy.

By 8.30am we had a CT scan done on her, also within seconds. I rang the consultant radiologist, who was able to view the image remotely, and thought it looked a bit patchy.

By 9am I had rung her oncologist and he was able to see her by 10am.

She saw me at 6am and within four hours was able to be diagnosed and with her specialist because we have so many services under one roof.
Leg pain at night: Is it serious?

The differential diagnoses for this case scenario should include the possibility of a bone tumour, infection, a seronegative arthropathy, an injury or non-specific leg pains. Fortunately the latter is the most common presentation, but the sinister nature of a tumour always warrants consideration and investigation (eg imaging, blood tests). The non-articular location of the pain site suggests that a seronegative arthritis is less likely; similarly the daytime normality indicates that infection or injury (eg greenstick fracture) is less suspect.

In an otherwise well and happy child such as Jessie, the cause of such a presentation is most likely to fall under the ‘growing pains’ label. While often met with howls of derision, growing pains is a legitimate (if ill-defined) condition. Although there is no single pathognomic test for growing pains, it can be diagnosed on the basis of both inclusion and exclusion criteria (see Table 1). If the stipulated criteria are observed and adhered to, misdiagnoses of children with less common but more serious conditions are unlikely. A recent matched case-control study concluded that growing pains remains a clinical diagnosis and if the precise inclusion and exclusion criteria are considered, there is only need for laboratory tests and imaging in aberrant instances.

Jessie’s case is, however, somewhat atypical of a child with growing pains: in that the pain appears to be unilateral and sensitive to touch during episodes. It may be that in her sleepy distress, Jessie only complains of one leg hurting and is generally irritated, hence not allowing the parents to touch it. Careful questioning of the parents may elucidate these points further but it is important to appreciate the greater likelihood of a more focal lesion with persistent unilateral leg pain and arrange for imaging to clarify this point. In 70% of affected cases, growing pains have been found to affect a parent or sibling, so this point is worth investigating with the family while maintaining clinical objectivity.

Although growing pains are prevalent (have been found to affect as many as 35% of children aged 4–6 years),2 distressing and familial, they seem to be confined to childhood, abating by the end of the second decade. Restless legs syndrome, although less common, also occurs in children (approximately 1–2%) and is being increasingly recognised as another entity that causes not only sleep disturbance, but has wider health associations including behavioural issues, learning difficulties, obesity, mood and general health deficits. The cardinal sign, which may clinically help to distinguish restless legs syndrome from growing pains, is motor restlessness. Children with restless legs syndrome tend to be fidgety (can be confused with ADHD) and have an uncontrollable urge to move their legs (as do adults with this condition).3

MANAGEMENT

Maintaining vigilance with respect to the diagnosis by exclusion and slightly atypical presentation as noted, the most likely condition to manage for Jessie and her parents is growing pains.4

The best available evidence for the management of growing pains comes from a small Canadian randomised controlled trial in children aged 5–14 years. This trial supported the efficacy of leg muscle stretching exercises (see Table 2).10 However the study was biased, with no examiner blinding and small sample sizes.10 Leg muscle stretching should be the first-line approach by clinicians and can be supplemented with what parents already tend to do – that is, rubbing and dosing (and gastro-renal groups. All stretches were performed twice daily (morning and evening) for 10 minutes each time.

CONCLUSION

In summary, the main points and suggested approach to the management of Jessie are:

• Leg pain, designated as growing pains, is prevalent in young children and is usually familial.
• The diagnosis of growing pains is made clinically using the inclusion and exclusion criteria.
• The best evidence for the management of growing pains is muscle stretching of the quadriceps, hamstrings and trochanteric groups.
• Clinical presentations deviating from the typically benign growing pains must be further investigated (referral of the patient to a paediatrician or paediatric rheumatologist should be considered).11

Most cases of growing pains will present with episodic, spates, a family history and the inclusion and exclusion criteria of that included in Table 1. It is critical that deviation from these findings be more widely investigated, such that the less frequent but more sinister differentials (eg. tumours, infections, seronegative conditions) are not missed.

TABLE 1. DEFINITION OF GROWING PAINS – INCLUSION AND EXCLUSION CRITERIA

<table>
<thead>
<tr>
<th>Pain factors</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of pain</td>
<td>Intermittent</td>
<td>Persistent</td>
</tr>
<tr>
<td>Unilateral or bilateral</td>
<td>Bilateral</td>
<td>Unilateral</td>
</tr>
<tr>
<td>Location of pain</td>
<td>Anterior thigh, calf, posterior knee – in muscles</td>
<td>Joint pain</td>
</tr>
<tr>
<td>Onset of pain</td>
<td>Late afternoon or evening</td>
<td>Pain present the next morning</td>
</tr>
<tr>
<td>Physical examination</td>
<td>Normal</td>
<td>Swelling, erythema, tenderness</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>Normal</td>
<td>Reduced joint range of motion</td>
</tr>
<tr>
<td>Limitation of activity</td>
<td>Nil</td>
<td>Reduced physical activity</td>
</tr>
</tbody>
</table>

** Group 1 – treatment Muscle stretching acetylsalicylic acid
n = 18
Beginning of trial 10 10
3 months 1 6
9 months 2 3
18 months 0 2

* Parents were taught a muscle stretching program for quadriceps, hamstrings and gastro-renal groups. All stretches were performed twice daily (morning and evening) for 10 minutes each time.

Medicine Today provides Going Places with selected articles from its archive of peer reviewed clinical content. To view the full archive, visit Medicine Today’s website at www.medicalintoday.com.au or download the new Medicine Today for iPad, available from the App Store at https://itunes.apple.com/app/id66623264

Registration is free to all members of GPRA, GPSN and GPN.

Taking a fresh look at general practice 37
Fishing for competence

By Dr Marcus Gunn

One of the things I enjoy most about having a registrar in the practice is being able to demonstrate my range of practical procedures. The medical schools seem pretty good at cramming their students full of arcane facts, but when it comes to hands-on skills, I always find gaps that I can fill.

An old favorite is nail bed phenolisation for ingrown toenails. It’s nearly impossible to find a surgeon in the area who will design to perform such a simple yet effective procedure these days, and anyway there’s something intensely satisfying about rootling around under the nail fold in search of that little bit of nail plate. It’s the one procedure that each registrar leaves my practice able to do competently and safely.

A unique opportunity presented itself recently when a middle-aged diner from the restaurant across the road was rushed through the door during evening clinic. Only the registrar — Sophie, fresh out of hospitals and I were in the building and it was clear from the woman’s anxiety that she needed help quickly. She was sitting forward with her jaws agape and saliva pooling on the floor, waving furiously at her mouth with both hands. Her eyes were flooded with tears, her mascara making her look like a panicked panda. A smartly dressed man turned from browsing the shelves in the treatment room to inform me languidly:

“Margaret’s the name. She’s got a fish bone. Stuck. In her throat.”

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

“Perhaps I could …” murmured Sophie, taking the forceps in her gloved hand.

Sitting up in the back of the woman’s pharynx was a fishbone the size of a toothpick. It appeared to have stabbed into the back of her left tonsil and the other end was wedged up behind her uvula. Clearly it had to come out.

Too scared to take my eyes off the bone in case it disappeared, I scrabbled furiously in the drawer behind me for something to grip it with. My hand lit upon a screwdriver and a pair of pliers, neither of which seemed quite right for the task, while Sophie quietly unwrapped a pair of sponge forceps and pressed them into my palm.

“Right, Margaret” I said, lining up the bone and steadily advancing the forceps.

“Hold really still.”

The forceps brushed the back of her pharynx and Margaret’s tonsils seized them, shook them furiously and hurled me back against the wall. The poor woman gagged desperately. Sophie coughed under her breath; it sounded suspiciously like “… xylocaine …”. Taking the bottle of xylocaine spray off the nearby shelf, I gave Margaret’s pharynx a lavish spray.

What followed then were several minutes of pitched battle as I attempted to pass my forceps over the back of Margaret’s tongue and get a grip on the bone. We were both sweating profusely by the time I slumped back in my chair, exhausted.

“Tongue out, please, Margaret,” she said. Margaret duly protruded her tongue and Sophie seized it in a piece of gauze, drawing it out further until Margaret’s mouth opened up like a cash register. She deftly swooped in, drew the bone out like a sword from a scabbard and dropped it in the sink.

Margaret gave a few exploratory swallows and relief spread across her bleary face. Her husband applauded ironically.

“Nice work,” he said. “Now we can get back in time for dessert.”

As we were tidying up the treatment room I complimented Sophie on her expertise. It was only then that she reminded me that she had done a special skills post in ENT and ophthalmology, thinking the techniques might come in useful in general practice.

“Ready, Margaret” I said, lining up the bone and steadily advancing the forceps.

“Hold really still.”

The forceps brushed the back of her pharynx and Margaret’s tonsils seized them, shook them furiously and hurled me back against the wall. The poor woman gagged desperately. Sophie coughed under her breath; it sounded suspiciously like “… xylocaine …”. Taking the bottle of xylocaine spray off the nearby shelf, I gave Margaret’s throat a lavish spray.

What followed then were several minutes of pitched battle as I attempted to pass my forceps over the back of Margaret’s tongue and get a grip on the bone. We were both sweating profusely by the time I slumped back in my chair, exhausted.

“Perhaps I could …” murmured Sophie, taking the forceps in her gloved hand.

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

**Aqueous humour**

“Perhaps I could …” murmured Sophie, taking the forceps in her gloved hand.

One of the things I enjoy most about having a registrar in the practice is being able to demonstrate my range of practical procedures. The medical schools seem pretty good at cramming their students full of arcane facts, but when it comes to hands-on skills, I always find gaps that I can fill.

An old favorite is nail bed phenolisation for ingrown toenails. It’s nearly impossible to find a surgeon in the area who will design to perform such a simple yet effective procedure these days, and anyway there’s something intensely satisfying about rootling around under the nail fold in search of that little bit of nail plate. It’s the one procedure that each registrar leaves my practice able to do competently and safely.

A unique opportunity presented itself recently when a middle-aged diner from the restaurant across the road was rushed through the door during evening clinic. Only the registrar — Sophie, fresh out of hospitals and I were in the building and it was clear from the woman’s anxiety that she needed help quickly. She was sitting forward with her jaws agape and saliva pooling on the floor, waving furiously at her mouth with both hands. Her eyes were flooded with tears, her mascara making her look like a panicked panda. A smartly dressed man turned from browsing the shelves in the treatment room to inform me languidly:

“Margaret’s the name. She’s got a fish bone. Stuck. In her throat.”

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

Taking the forceps in her gloved hand.

**Fishing for competence**

By Dr Marcus Gunn

One of the things I enjoy most about having a registrar in the practice is being able to demonstrate my range of practical procedures. The medical schools seem pretty good at cramming their students full of arcane facts, but when it comes to hands-on skills, I always find gaps that I can fill.

An old favorite is nail bed phenolisation for ingrown toenails. It’s nearly impossible to find a surgeon in the area who will design to perform such a simple yet effective procedure these days, and anyway there’s something intensely satisfying about rootling around under the nail fold in search of that little bit of nail plate. It’s the one procedure that each registrar leaves my practice able to do competently and safely.

A unique opportunity presented itself recently when a middle-aged diner from the restaurant across the road was rushed through the door during evening clinic. Only the registrar — Sophie, fresh out of hospitals and I were in the building and it was clear from the woman’s anxiety that she needed help quickly. She was sitting forward with her jaws agape and saliva pooling on the floor, waving furiously at her mouth with both hands. Her eyes were flooded with tears, her mascara making her look like a panicked panda. A smartly dressed man turned from browsing the shelves in the treatment room to inform me languidly:

“Margaret’s the name. She’s got a fish bone. Stuck. In her throat.”

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

Taking the forceps in her gloved hand.

**Fishing for competence**

By Dr Marcus Gunn

One of the things I enjoy most about having a registrar in the practice is being able to demonstrate my range of practical procedures. The medical schools seem pretty good at cramming their students full of arcane facts, but when it comes to hands-on skills, I always find gaps that I can fill.

An old favorite is nail bed phenolisation for ingrown toenails. It’s nearly impossible to find a surgeon in the area who will design to perform such a simple yet effective procedure these days, and anyway there’s something intensely satisfying about rootling around under the nail fold in search of that little bit of nail plate. It’s the one procedure that each registrar leaves my practice able to do competently and safely.

A unique opportunity presented itself recently when a middle-aged diner from the restaurant across the road was rushed through the door during evening clinic. Only the registrar — Sophie, fresh out of hospitals and I were in the building and it was clear from the woman’s anxiety that she needed help quickly. She was sitting forward with her jaws agape and saliva pooling on the floor, waving furiously at her mouth with both hands. Her eyes were flooded with tears, her mascara making her look like a panicked panda. A smartly dressed man turned from browsing the shelves in the treatment room to inform me languidly:

“Margaret’s the name. She’s got a fish bone. Stuck. In her throat.”

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

Taking the forceps in her gloved hand.

**Fishing for competence**

By Dr Marcus Gunn

One of the things I enjoy most about having a registrar in the practice is being able to demonstrate my range of practical procedures. The medical schools seem pretty good at cramming their students full of arcane facts, but when it comes to hands-on skills, I always find gaps that I can fill.

An old favorite is nail bed phenolisation for ingrown toenails. It’s nearly impossible to find a surgeon in the area who will design to perform such a simple yet effective procedure these days, and anyway there’s something intensely satisfying about rootling around under the nail fold in search of that little bit of nail plate. It’s the one procedure that each registrar leaves my practice able to do competently and safely.

A unique opportunity presented itself recently when a middle-aged diner from the restaurant across the road was rushed through the door during evening clinic. Only the registrar — Sophie, fresh out of hospitals and I were in the building and it was clear from the woman’s anxiety that she needed help quickly. She was sitting forward with her jaws agape and saliva pooling on the floor, waving furiously at her mouth with both hands. Her eyes were flooded with tears, her mascara making her look like a panicked panda. A smartly dressed man turned from browsing the shelves in the treatment room to inform me languidly:

“Margaret’s the name. She’s got a fish bone. Stuck. In her throat.”

“Ah,” I said, peering into the depths with a feeble torch. “It often feels like there’s a bone stuck when it’s only scat … Holy cow!”

“Barramundi, actually,” drawled the husband. “Drizzled with a lemon jus.”

Taking the forceps in her gloved hand.
Medical students and junior doctors have a steep learning curve when it comes to practical skills. Murtagh’s Practice Tips, 6th edition, is the latest edition of practical skill instruction. It consists of quick reference value tables of normal adult and paediatric vital signs, and instructions on how to perform many procedures, including a new emergency procedures section (eg. insertion of an intercostal catheter; cryochothyroidostomy; analphaxis management), and updated sections on basic medical procedures (including insertion of intravenous catheter; endotracheal catheterisation); to minor plastic surgery and management of skin lumps and bumps; nail conditions, removal of foreign bodies; ear, nose and throat and eye procedures. At university a sound academic knowledge is gained, but it can take months or years of experience to become proficient in practical skills. It is handy to have an accurate reference book which outlines an approach to each technique.

The eBook versions come with a video tutorial about how to navigate the book electronically, including changing font and image size to suit lap top, Pad or Phone (or Android equivalent), searching contents or images, and copying, printing and pasting book content. An excellent paperless way to access John Murtagh’s series with the knowledge at your and your patients’ fingertips.

John Murtagh’s general practice, practice tips, and patient education eBook pack

John Murtagh


John Murtagh’s General Practice is written with the recent graduate and medical student in mind. It provides the basic knowledge and skills required in modern general practice. The book emphasises early diagnosis, strategies for solving common presenting problems, continuing care and holistic management — all important in general practice. It also continues to highlight ‘conditions which must not be missed’ and ‘red flag pointers’. Murtagh attempts to provide current evidence-based information by using independent experts, including from Therapeutic Guidelines, to review chapters in their specific disciplines. These include Dr Jill Rosenblatt, Murtagh’s wife, who continues to provide input, especially in women’s health.

This edition has expanded chapters including genetic disorders, infectious diseases, tropical and travel medicine. It has several new chapters including refugee health, menopause and osteoporosis.

Patient education is one of the most important aspects of good patient management. Providing patients with written, take home information is a very effective part of this. Murtagh’s Patient Education provides valuable written handouts correctly explaining over 300 common conditions seen by GPs. The single A4 sheets discuss possible causes, signs and symptoms; prognosis and management of the conditions in non-technical language. It helps patients understand and manage their own illnesses. These patient education sheets are a collation of the handouts featured over many years in the RACGP’s journal, Australian Family Physician. The eBook version has a very handy format allowing location of the appropriate handout in the index, typing the page number in the Go to printed page icon, and printing it while with your patient.

The ideal way to use this book is to find a study group, to allocate roles and to work through each case during your study sessions. The cases are aimed at being informative and educational — there are specific instructions for the patient, for the doctor and for the facilitator and observers; and you could even get your family members involved in role-playing patients. At the end of the case there is a case commentary highlighting the relevant issues and common pitfalls. Dr Wearne also spends time giving guidance on how to run the cases, including time-keeping, giving constructive feedback and other advice that will help students get the ideal consultation framework and manage the ‘case’ appropriately.

Overall, I think Clinical Cases will be invaluable to any group of students preparing to sit general practice exams. It allows you to run through well-researched relevant cases with your peers in your own time, and also provides a framework and feedback for each case. Absolutely ideal!

As Dr Wearne states, clinical practice is still the best preparation for exams and this book aims to supplement clinical work and to help prepare students to exhibit the knowledge, skills and attitudes necessary for general practice, and for it, it achieves that very well.

Clinical cases for general practice exams — second edition

This book is still the best preparation for exams and this book aims to supplement clinical work and to help prepare students to exhibit the knowledge, skills and attitudes necessary for general practice, and for it, it achieves that very well.


Review by Dr Linda Thomson, Cairns Qld

General practice – the integrative approach

Kerryn Phelps and Craig Hassed

General Practice – The Integrative Approach is a thorough but accessible review of general practice. Australian authors Kerryn Phelps and Craig Hassed offer a reflection on general practice, which gathers key principles of general practice from its historical origins to contemporary health care. Long term GPs of public renown and with a history in public health and education, Phelps and Hassed are well placed to create an insightful and reinvigorated approach to general practice. Medicine is a dynamic profession, affected by scientific understanding law and our social and natural environments. This integrative approach fills a crucial space – empowering the generalist with a refreshed outlook on health care. It promotes a nuanced, evidence based, grounded approach to holistic medicine. It acknowledges the increasing need to care for our patients (and ourselves as practitioners) in the physical, social, emotional and spiritual domains, and that many patients favour the combination of complementary and biomedical practice.

The book is suited to the general practitioner, GP registrar or student. The text combines insights from an impressive array of contributors including GPs, physicians and surgeons. The text is structured into seven parts: principles of integrative medicine, principles of general practice, systems, men’s health, women’s health, lifestyle health and social conditions. Medical and surgical conditions are considered in a systems based approach, with a synopsis of relevant physiology and anatomy before a discussion of potential management with reference to current evidence. Chapters cover both common symptoms and diseases with brief synopses. Although comprehensive, the breadth necessitates some lack of detail, therefore to be an expert in an area will require further reading.

However, the writers work to be objective, specific and concise, therefore maximising the depth. A key asset of each chapter is an extensive list of resources and references. Subsequent to the main text is a long appendix detailing interactions between complementary and western medicine.

The text is easily read with tables and images, and full colour. The pages are very well laid out bringing the book to 3 kg in weight — one for the bookshelf or afternoon read in a sunny café or library. This is an excellent text for orienting the generalist to a rewarding career, with confidence that its authors will assist junior doctors in their pursuit of best practice.

General practice – the integrative approach is published by Churchill Livingstone, 2010. RRP $154.95

Review by Dr Jane Maxwell

Melbourne Vic

NextGenGP KICKSTART YOUR CAREER

REGISTERED GENERAL PRACTITIONER CONFERENCE & EXHIBITION

21 SEPTEMBER 2013

BRISBANE CONVENTION & EXHIBITION CENTRE

• Registrar-Specific Clinical and Industry Education
• Connect with major primary health companies
• Access to Australia’s largest healthcare exhibition
• Network with future colleagues and educators
• Kickstart your career with the GPCE
• Enhance exam training and preparation
• Get ahead in your profession!

To register visit www.gpce.com.au or call 1800 358 879

FREE REGISTRAR & MEDICAL STUDENT EDUCATION PROGRAM
Discover great opportunities within the AGPT program

The Australian General Practice Training (AGPT) program offers registrars the opportunity to undertake a variety of interesting and challenging training posts which exemplify general practice, including academic posts.

Undertake a salaried research project

The everyday practice of GPs is centered around evidence-based medicine. The AGPT program encourages registrars to undertake research and improve critical thinking.

As an AGPT registrar you can undertake an academic post — a paid, part-time research placement which allows you to undertake a research project, attend research workshops, present your work at national conferences and contribute to primary care research and teaching communities.

“Completing an academic post has provided me with a new set of skills that will be useful in both clinical and academic general practice. It has also opened up a wide range of opportunities I would have not been exposed to otherwise.

“I have had the funding and support to complete my own research project looking at how young men feel about GPs bringing up sexual health, and also create networks both within my university department and the wider research community. I presented my research findings at the Primary Health Care Research Conference in Sydney this year and was awarded the AMAC Best First Time Presenter Award. A small article outlining my findings was also published in Australian Doctor. Both of these achievements validated to me that my research has been well conducted, worthwhile and well received.

“Many teaching experiences during the academic post has involved both medical student tutorials and subject co-ordinating online post-graduate nursing subjects. Engaging with a group of medical students over some weeks was particularly rewarding.

“I hope to continue my involvement in academic primary care, both for the diversity and depth it adds to my clinical care, both for the diversity and depth it adds to my clinical care and the inspirational colleagues I have come across over the past year. I would recommend an academic post to any general practice registrar who knows, thinks or has ever thought they may be interested in research and teaching.”

Dr Sarah Latreille, GPT3 registrar / academic registrar

To find out more about the AGPT program visit gpet.com.au or talk to your regional training provider.

Where to now?

Join the Going Places Network

Becoming part of the Going Places Network at your hospital. It’s a fun way to network with others who have an interest in general practice, while developing your professional knowledge and credentials.

Looking for the Going Places Network at your hospital?
Visit gpaustralia.org.au to find out more and join online.

Talk to your GP Ambassador

Our GP Ambassadors are junior doctors who have a real passion and enthusiasm for general practice. They’ll be able to answer all your questions about general practice. If there are any questions they can’t answer, they’ll find the answers for you.

Visit gpaustralia.org.au to meet the GP Ambassador in your hospital or area — or look out for posters on notice boards in your JMO lounge.

Test-drive general practice with the PGPPP

The Prevocational General Practice Placements Program (PGPPP) is a great opportunity to experience life as a GP during your hospital training year. When you participate in the program you rotate into a general practice training post for a minimum of one, and a maximum of two hospital terms.

Throughout your placement you are well-supervised by experienced GP supervisors. You have management of your own patients and are involved in varied areas of health care, such as sexual health, drug and alcohol, aged care, paediatrics, home visits, and acute and chronic disease management.

Visit gpet.com.au to find out more about the PGPPP.

Get the A–Z on GP training

Ask your GP Ambassador for a copy of the Going Places Prevocational Doctor’s Guide to General Practice Training — your comprehensive guide to becoming a GP. They’ll also be able to provide you with a copy of the AGPT (Australian General Practice Training) 2013 handbook, which has full details about the AGPT program.

Visit gpaustralia.org.au

To find out how general practice training works, visit gpaustralia.org.au. It will guide you through the pathways available, the organisations involved, the nuts and bolts of applying and more, helping you to plot your path into general practice.
At Healthscope, our Medical Centres are focused on the career development and education of our Practitioners.

We offer young doctors the opportunity to work in modern facilities with access to high quality equipment and resources across various locations in Australia.

We also provide ongoing national training and education opportunities, with a major focus on Chronic Disease Management in primary care, and encourage young doctors to pursue areas of special interest to foster their growth.

With flexible hours and employment packages on offer, our centres provide a supportive administrative environment for young doctors looking to enhance their professional development.

To learn more about the benefits of joining a Healthscope Medical Centre
Please contact Angela Li on 03 9926 7725 or angela.li@healthscope.com.au