September 2009 Volume 71

Network e-Newsletter

Hastings Macleay General Practice Network Ltd.

Ageing with Style Conference & AGM

The 2009 Annual conference and AGM will be held at the Glass House Port Macquarie on 19 September 2009.

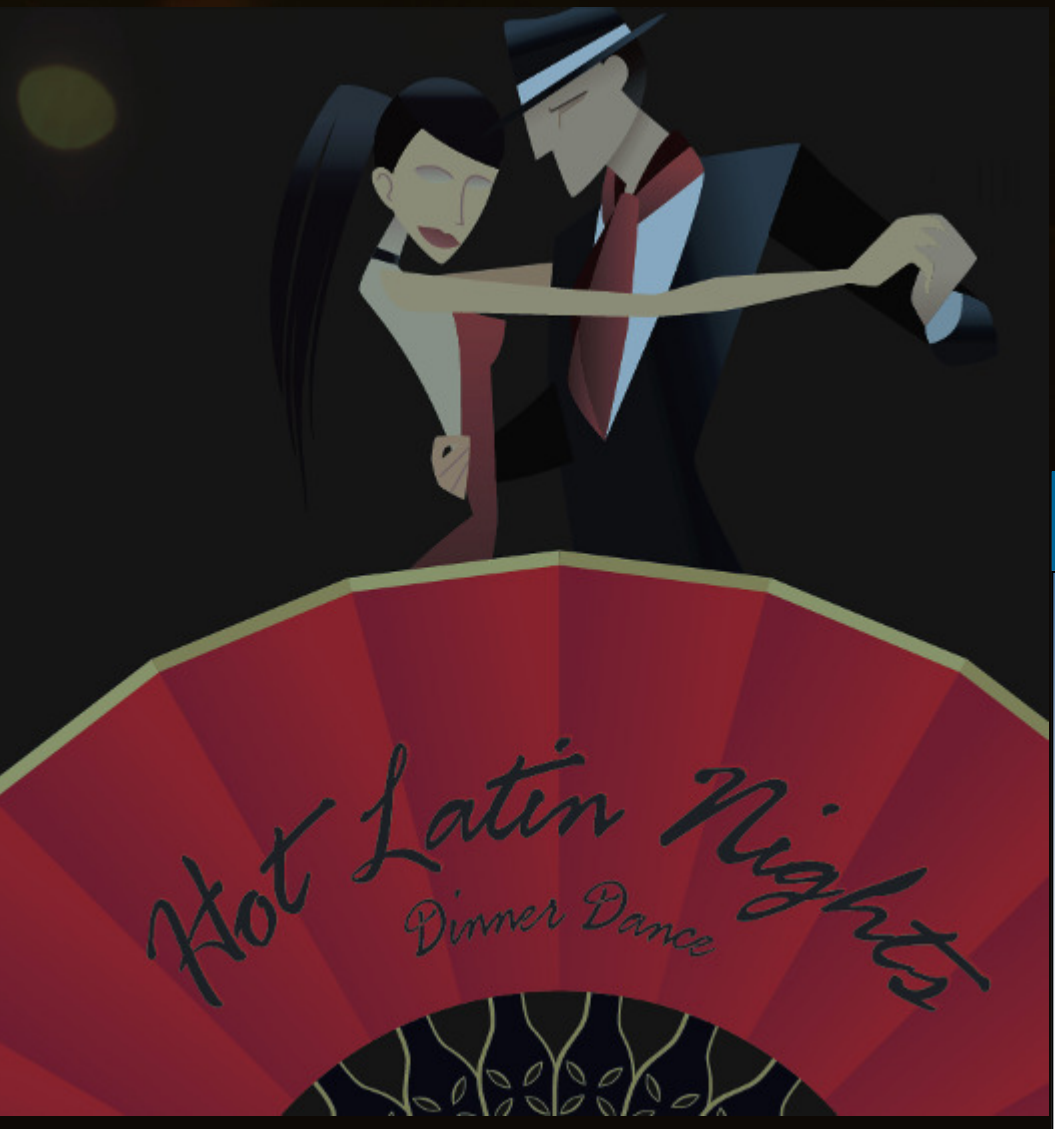
Dr Debbie Kors and her organising team have developed an excellent program which includes three streams Clinical, Management and Well Being providing concurrent sessions throughout the day.

The AGM will take place at 4.45pm and should be finished by 5.45pm in time for you to go home and get changed into your hot Latin nights outfits for the Dinner Dance commencing at 7.00pm. Music will be provided by the Flammin Bullantz again this year.

Please RSVP to Libby Mackintosh-Sallaway by no later than:

Monday 7 September 2009

PLEASE NOTE THAT THE DINNER DANCE IS FOR ADULTS ONLY so no children please.



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HMGPN Services

Locums

Please ring Helen at the Network if you have any interest in undertaking Locum work or are aware of anyone else who may be considering this as an option.

- **Dr David Leggett** 6566 6636
- **Dr Ron Smith** Kempsey .....6562 4148 ..... 0428 654 087
- **Dr Clem Moran** Camden Haven....6559 8842

- RRMA 3-7 can contact Sally on 6742 1339 or email Smangelsdorf@barwondgp.org.au
- **Medical Relief Staff** 9957 1166
- **Australian Medical Placements** .....08 8443 4455..... 08 8443 4466 medplace@webmedia.com.au
- **Sinclair Consulting Group** .....9957 5463 ..... 0439 951 957 mail@sinclairconsulting.com.au | www.sinclairconsulting.com.au
- **Ochre Recruitment** .....0408 721 482..... Fax 03 6224 8466
  Level 4/18 Elizabeth St, Hobart 7000 | GPO Box 2071, Hobart 7001
  Email: caroline@ochrehealth.com.au | nicole.g@ochrehealth.com.au
  Web: www.ochrerecruitment.com.au
- **NSW Rural Doctors Network Locum Service**—Kate Perrett ..... 02 6742 3633 or locumnorth@nswrdn.com.au

Claim Forms Available

(Download from www.hmgpn.org.au then click on Member Resources)

Education Subsidy: Applications for financial assistance funded by the OBF and WSRGP budgets must be obtained and granted PRIOR to the event and claimed within TWO MONTHS of the event. Please note that subsidies cannot be used to meet examination expenses.

The applications must be received on the network Education Subsidy Form and are limited to three applications per member up to a maximum of $1250.00/application for Port Macquarie members and $1500.00/ application for members who practice outside Port Macquarie.

The Network actively encourages and welcomes input from our members. If you would like to contribute to our Newsletter, please contact:

Helen on 6583 3600

Staff

Paul Ward ..... Chief Executive Officer ..... pward@hmgpn.org.au

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Chairmans Report

David Gregory

The National Health and Hospitals Reform Commission(NHHRC) has given its final report to the Minister of Health and Ageing and it has been released to the public. The NHHRC was set up 18 months ago by this government with the task of setting health reform agenda for the next 10 years and beyond. The report is over 200 pages and has 123 recommendations for the health system as a whole. There are recommendations that directly affects primary care and general practice. A summary of these has been prepared by AGPN and was emailed to all GPs last week by Paul Ward.

Of particular relevance to the network is the recommendation that Primary Health Care Organisations (PHCO's) be established that either evolve from or replace the existing Divisions of General Practice. It is suggested that 40-60 such regional entities form with an average catchment population of 300,000-500,000 and that all aspects of primary care are represented. This would include physios, psychologists, dieticians, pharmacists, nurses involved in primary care and so on.

According to the report the role of these new organisations would be to support, enhance and integrate primary care delivery in that geographical area. Also to measure health outcomes and to act on these at that regional level. The report suggests that these organisations do not fund hold but that another regional entity such as a health trust, funded by federal and state governments control funds for PHCO's and other health spending in the region. It is proposed that the Commonwealth Government take over all health costs immediately except inpatient hospital care and that be taken over in time. Although the state would continue to own and operate the public hospitals.

It is important to emphasise that these are recommendations and not government policy. The Health Minister has also received the Primary Health Care Strategy report and the Preventative Health Taskforce report but has not released these. There is also an ongoing MBS Reform report which is due to be released. The Commonwealth Government may decide to adopt all, some or none of these recommendations. In the current political climate, members should consider likely outcomes for themselves.

So far our GP Network has had discussions with Mid-North Coast Division of General Practice (Coffs Harbour), Northern Rivers General Practice Network (Lismore/ Ballina), and the Tweed Valley General Practice Network. As well as North Coast General Practice Training that covers the whole region. The five organisations also align with the North Coast Area Health Service. The area population is about 500,000. So far discussions have been around ways to share resources and how a merger could be considered.

The time frame is that by November there should be a clearer government response. If the recommendations of the report affecting the GP Network are adopted there would be three years to change or not. Change would involve merging, expanding our membership and changing our role. Such changes would need the support of the members.

I hope there will be time at the upcoming AGM and Education Weekend to discuss these interesting developments. It may be necessary to arrange meetings later this year or early next year. Either way I hope to see you all at the AGM. Remember that great adage. "Decisions are made by those who show up".

Immigration & Helicobacter pylori

Dr. Aruni H.W. Mendis & Prof. Barry J. Marshall. FRACP, FAA, FRS, Nobel Laureate

Addressing **recent migrations**, a retrospective audit by the Victorian Infectious Diseases Service at the Royal Melbourne Hospital was carried out on 375 patients from the sub-Saharan-region. All patients attended the infectious diseases clinics of a Melbourne teaching hospital. The study[1] indicated that H. pylori (Hp) gastritis was diagnosed in 60% of those tested (35/58s). Hp is becoming rarer in Australians born here. As a result, it is likely that the gastric pathology will be seen mostly in immigrants & those who associate with them. It is important that clinicians be aware of these risk-factors to meet the health needs of these groups. Comprehensive health checks including checks for Hp should be encouraged for new arrivals.

Ancient migrations were studied[2] recently by Professor Barry Marshall, Dr Helen Windsor (UWA) and colleagues from the Max Planck Institute in Berlin, who linked human habitation of the Pacific region to the development of two distinct strains of H. pylori (Hp). The research (published in 2009) revealed that about 40,000 years ago Hp had split into two distinct populations, **hpSahul** and **hspMaori**. The split was in accordance with accepted prehistoric migrations into the Pacific, with the **Sahul** strain splitting again into New Guinean and Australian strains up to 32,000 years ago (but not 40,000 years ago[3]) and the other extending through Melanesia and through to the Polynesian islands.

1. Gibney KB, Mihrshahi S, Torresi J, Marshall C, Leder K, Biggs BA.(2009) The profile of health problems in African immigrants attending an infectious disease unit in Melbourne Australia. Clin.Microbiol.Rev.2009 Apr; 22(2):202-223
2. Yoshan MoodLey, Bodo Linz, Yoshio Yamaoka, Helen M. Windsor, Sebastian Breurec, Jeng-Yih Wu, Ayas Maady, Steffie Bernhoft Jean-Michel Thiberge,Suparat Phuanukoonnon, Gangolf Jobb, Peter Siba, David Y. Graham, Barry Marshall ,Mark Achtman. SCIENCE Vol. 323, p 527-530
3. Gillespie R. Dating the first Australians. RADIOCARBON, Vol 44, Nr 2, 2002, p 455–472.

CEO Report

Paul Ward

Dr David Gregory has in his report talked about the Federal Governments reform agenda for Primary Care in Australia. The Health and Hospital Reform Commission report has acknowledged the Governments "***15 years worth of investment in the Divisions of General Practice Program"*** and noted that "***this infrastructure would make the logical platform on which to build regional networks of Primary Health Care Organisations to improve population health planning and regional delivery of primary health care services, integrating closely with general practice".***

Over the past six months the Board has been having discussions with North Coast GP Training and the other three Divisions of General Practice on the North Coast to investigate setting up an entity which would see these organisations come together to develop funding applications for programs that would be mutually beneficial to all concerned. Coincidentally with the release of the Federal Government Reviews this entity could also provide the vehicle to have an overarching role in primary health care service coordination and delivery on the North Coast.

In preparation for what we believe will be big changes to how primary health care is delivered and in preparation for the proposed Centre of Excellence the Network has embarked on a restructure of its Committees and staff structures and has also decided to focus considerable energies on re-engaging with our Members.

It is our understanding and belief that some GPs and Practices have felt that the Network is too busy doing "it's" stuff and that we don't take enough time to listen to GPs about their issues and to provide support where it is really needed. In response my role as CEO of the Network is evolving and will now encourage more Member engagement.

The annual visits, introduced in 2007 have been a good way of getting Member feedback but in 2009-10 the format and frequency of the visits will change with the emphasis on meetings being arranged when needed and requested. I have decided to make the process more personal and will be inviting GPs to meet with me on a one to one basis at a time and place of their choosing. These meetings combined with the new Professional Support Association Working Party will give the Board a more appropriate and useful mechanism for receiving your feedback on issues that affect you and your practice.

We revised our staff structure and set up a level of middle management where staff now report directly to a manager according to their roles. This in turn will allow me time to get out there more often to hear what the Members and Stakeholders are saying.

We now have 2 Committees and 3 Working Parties with GPs on the Committees being appointed as part of the AGM process and those on the Working Parties being a time limited Board appointment.

The new Committees are as follows:

- **The Clinical Services Committee**

Bob Boss-Walker as Manager Clinical Services will resource this Committee which will encompass all the clinical programs we deliver (Access to Australian Psychological Services, Mental Health Nurse Initiative, More Allied Health Services, Aged Care Access Initiative, Lifestyle Modification Program, Medical Specialists Outreach Assistance Program, Mood Assessment Program)

- **The Network and Practice Support Committee**

Christine Cox as Manager Network and Practice Support will resource this Committee which will encompass all the Practice Support Programs we offer (Argus Secure Messaging, Australian Primary Care Collaboratives, National Prescribing Program, Home Medications Review, Practice Manager and Practice Nurse training and support, Immunisation, After Hours roster, Doctors Health Program, Rural Palliative Care Program, Workforce Support for Rural General Practitioners, GP Research Grants and the GP Education Program)

The new Working Parties are as follows:

- **GP/Hospital Working Party** – This Working Party comprises 4 GPs, 2 Network staff and senior representatives from the North Coast Area Health Service and Port Macquarie Base Hospital. The main purpose of this Working Party is to keep each other informed on issues that affect GPs, the hospitals and patients and to look for solutions to these issues. GP input is vital here so please don't hesitate in contacting either Drs Debbie Kors, Peter Ackerley, Warwick Hain or Mike Birrell if there is something you want addressed.

- **Cancer Screening Working Party** – This Working Party comprises three GPs, Network staff and three cancer Specialists with a brief to examine possible collaborative projects in our area. Contact Dr Sharon Sykes for input into this Working Party.

- **Professional Support Association Working Party** – This Working Party comprises 3 Board Members and myself and is designed to be a forum where your issues, suggestions, etc can be heard and acted upon. Drs Jeremy Crawford, Robert Clarke and Debbie Kors are there for you to contact when you need to. Issues such as supporting you through

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CEO Report

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Medicare Audits and the development of a local voice for GPs for liaison with politicians, RACGP, AMA, Government Departments, etc are high on the agenda for this Working Party.

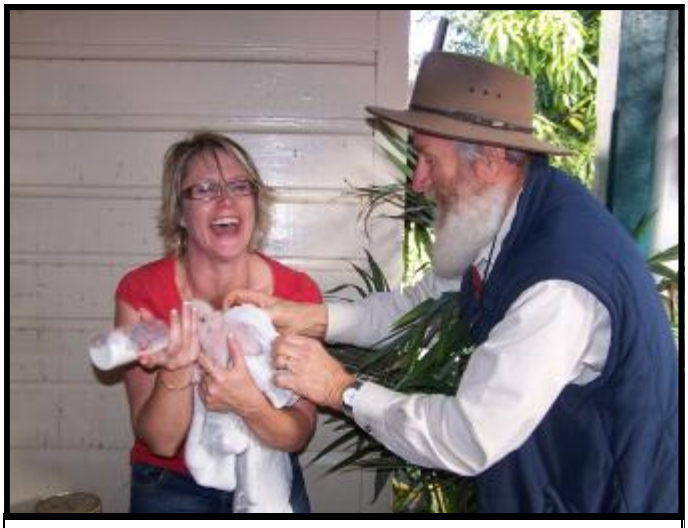
You should have already received your program and invitation to the 2009 Annual Conference and AGM which is being held at the Glasshouse Port Macquarie on 19th September 2009. The notice of the AGM along with nomination forms for Board and committee places has been sent to all Primary Members. The Agenda, 2008-09 Annual Report and Audited Financial Report, the Minutes of the 2008 AGM and any Motions of Special Business will be sent to Primary Members on 28th August 2009.

Dr Debbie Kors and her organising Committee of Chris Cox, Libby Mackintosh-Sallaway and Helen Bicket have developed an excellent program that has 3 streams of concurrent sessions (Clinical, Management and Wellbeing). In addition a fancy dress dinner dance (hot Latin nights theme) has been organised for the Saturday night at the Mercure Centro.

I hope to see you there

Out & About

Drs Taylor, Cain, Ackerley and Mujahid at the Macleay family day



This little piggy .... & Dr Paul Appleton

Medical Director training

Anticoagulant talk by Dr Richard Stark

THE SPECIALIST

I am writing in regards to our work here in Hoi An. I am a US-based internist and intensivist who came to Vietnam shortly after finishing a pulmonary and critical care fellowship. I had been working in Vietnam for some years prior doing relief work in a government-run orphanage. After living in Vietnam for a few months I came to realize the vast disparity between healthcare for the wealthy and poor in rural Vietnam.

Though this disparity is seen worldwide, I had never seen it to the degree that I did in the countryside in Quang Nam Province. There is a lack of any substantial care for those with chronic diseases who don't have money and live outside the city (this is the majority of people in Vietnam). Debilitating strokes from uncontrolled hypertension are common and patients aren't on any medication either to prevent a future stroke or to control blood pressures. Diabetes is largely unrecognized by the medical providers and its not uncommon to find blood sugars above 20 mmol/dl.

Seeing this changed the scope of our work. We turned over the orphanage work to others and changed our goal to improve basic healthcare for those who have no access to it. Our plan involved targeting the major diseases in this population (diabetes, hypertension and respiratory disease) and working to improve the management of these through patient education and empowerment, physician training and direct patient care.

Though the road in front of us is long and fraught with obstacles, we are determined to improve the quality of life and health of those less fortunate. We have recently opened our program to outside physicians welcoming an international wealth of knowledge and expertise to achieving our goal. We were very fortunate to have David Cooke and Judy Avenell work with us. They were able to work with our program by caring for patients and educating providers. We, as well as the Vietnamese community appreciate their assistance and we hope to have others like them bring their skills and compassion to help.

Josh Solomon, MD

THE DOCTOR

Five am. The loudspeakers on telegraph poles blare out scratchy music to wake the populace and induce them to start their day's work. I wonder why they couldn't wait another hour or so to let me sleep till a reasonable time. Later in the day the tourists will be entertained with Vivaldi broadcast from those same speakers.

Already the day is heating to its 35 degree and 98% humidity, and the hazy sun beats down on the ever busy roads. Motorbikes and pushbikes stream in a procession past the hotel in a seemingly chaotic traffic system that strangely appears to work. It is not unusual for a bike to accommodate four people weaving like fighter pilots with incessant tooting of horns.

At 7.30am my nurse Judy Avenell and I are picked up by two young interpreters, An and Nguyet, and, hanging on we enter the traffic for a clinic out of the town of Hoi An. After twenty minutes we are still alive and Judy has managed to open her eyes for the last two kilometres.

We enter the clinic building which is proudly shown to us by the local "EC", a man trained somewhere between a nurse and a doctor. A fan is fetched and Judy begins to screen the patients for diabetes and blood pressure before handing them on to myself and Mai, an Australian nurse who manages the Hoi An Foundation and has been here for many years. American doctor, Joshua Solomon started the organisation some years ago and spends many months of each year in Vietnam.

The people are gentle and appreciative but suffer from these two diseases due to the high salt and sugar content of their diet. "Are you taking the tablets?" the interpreter asks on my behalf. "No, I felt better," is a common answer and indicative of the amount of education these patients need about their treatment.

I sigh and the interpreter explains that the blood pressure is 200/100 and that this fifty year old is at risk of stroke. We give advice and prescribe the available medications some of which we stopped using in Australia twenty years ago. One such is Cozaar I note, stopped in a hurry in the western world because of serious side effects, and so I take people off this treatment. I wonder why we are doing this work when there are locally trained doctors until I learn that they have no continuing medical education, never meet for discussions and are reluctant to share any medical information.

With vast amounts of bottled water to counteract the enervating heat, we wade through the day seeing more heart murmurs in my three weeks in Vietnam that I have seen in forty years of Australian practice. It is largely rheumatic disease with a smattering of Fallot's tetralogy and septal defects. These go unrepaired in the majority of cases due to the cost ($US5000) of surgery for people whose annual income may be around $US600. These people would be lucky to reach twenty years of age.

I see wounds from the "American War" and there seems no resentment by these ex Viet Cong men and women. "That was then," they say, "this is now."

The pathology is gross and plentiful - hydrocephalus, Marfan's syndrome, cerebral palsy, marked clubbing and of course the horrific effects of Agent Orange.

The people seem happy and accepting of their situation, and, as

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Outreach... Vietnam

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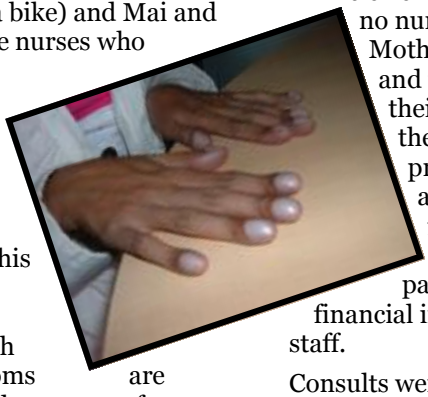
doctor is spelt "GOD", I seem to have more success in getting patients to stop smoking than in Australia.

Today we see about seventy patients although each day is totally different. Some days we travel far out into the countryside while others involve loading the bike on a ferry and working across the river on one of the many islands.

What a momentous experience. What a learning curve! My wife and I live in a comfortable hotel for $US25 a day including breakfast and it is possible to eat for $US7 - 8 per day.

Would I go again? Ask me in a year's time when I've got over the exhaustion, but probably Yes. The two Vietnamese girls, Nguyet and An are stimulating, energetic and full of knowledge, (as well as being clever on a bike) and Mai and Carol, two Aussie nurses who run the Hoi An foundation are truly inspirational, dedicated and selfless.



Three weeks of this experience and I return to my Lighthouse Beach Surgery. The rooms are airconditioned, there are no frogs jumping across the floor and the computer generated scripts for modern medicines are paid for by the government. A man needs heart surgery and is taken by air ambulance to Sydney where a surgeon will perform the operation at no cost to the patient.

I muse on the difference and I shall never be the same again.

Dr David Cooke

THE NURSE

I recently accompanied Dr David Cooke and his wife on a trip to Hoi An in Vietnam to work for two weeks as a volunteer RN in a range of clinics and it was worth the trip just to make me appreciate the benefits of the Australian health care system.

The Vietnamese are a gentle polite people and don't seem to complain about their lot in life. For example, in Australia we panic when a patient's blood pressure gets above 140 yet the local people in Hoi An still keep working in the rice fields with blood pressures of 200/100 and with high blood sugar levels. The elderly patients you see who manage to walk although totally bent over from the waist are evidence of the long hours many spend in the rice field.

The hospital was a real eye opener: it was grossly overcrowded with patients and family members, a complete absence of medical staff and on top of that no air conditioning with temperatures regularly reaching forty degrees. In the children's ward, beds are pushed together in twos and commonly accommodate three children and their mothers. Parents – generally mothers – have to stay with their sick children 24 hours a day as no nursing care is provided. Mothers have to provide food and feed themselves and their children, take them to the toilet and generally provide all nursing care and attention. It's a sad fact that often in order to get medical care, patients have to offer a financial incentive to the clinical staff.

Consults were time consuming and frustrating because of the language barrier. Everything had to go through one of the two wonderful translators but I really do think some things got "lost in translation". Sometimes we would ask a question of a patient via the translator which would result in a lengthy conversation between the two and then we would be told by the translator a one word answer such as "yes". You couldn't help wondering what else had been said. This tedious exchange process meant trying to give advice or suggest a change was really out of the question. Watching the exchanges between the interpreter and patient was sometimes quite off-putting when the patients had gashes of red and black betel nut stained mouths and teeth but there would be no point telling them of the dangers of betelnut to your health.

Sometimes the sensibilities of the translators wouldn't allow them to ask personal or sensitive questions and one time we asked a translator to tell an older female patient about an exercises that would improve the patient's pelvic floor, but she refused – presumably because she felt it was disrespectful. On the other hand when it came to examining patients that involved them opening up their clothes, there seemed to be little embarrassment despite a very curious and interested audience who were waiting for their turn with the Doctor or Nurse.

In the Clinic all patients file into the room, rest on the bed and "sit-in" on the current consult, either chatting among themselves or joining in until it's their turn with the doctor. If members of "the party" wish to consult with the doctor they put their medical information on the desk and are seen straight away.

We found patients were happy to keep taking their western medicine until they felt better and then, generally, they stopped taking it presumably because they felt it had done its job. They were happy, however, to continue taking their traditional medicines on a long term basis.

Many of the Vietnamese people I met were wonderful and doing a great job but I was particularly impressed with an Australian EN called Mai who worked in Vietnam for eight months a year as a volunteer and then spent four months in Australia working in private nursing to fund the next eight months in Vietnam. Truly inspirational.

Judy Avenell

Bob Boss-Walker

Medics avoid mental health help

Adapted from: http://news.bbc.co.uk/2/hi/health/8187286.stm accessed 24/10/2009

The vast majority of doctors would not seek medical help for mental health problems, a British survey suggests. Career worries, professional integrity and stigma were listed as the main reasons for doctors' reluctance to seek help for problems such as depression.

Medics are more likely to discuss mental health problems with family and friends, the survey of 2,500 doctors in Birmingham reported. The researchers said such reluctance could put doctors and patients at risk.

The anonymous survey, published in the journal Clinical Medicine, is the first of its kind outside the psychiatric profession. It found only 13% of respondents would choose to disclose their illness to a GP or another health professional.

And when it comes to inpatient treatment, 79% would opt for treatment in either a private or distant facility, rather than be treated by local NHS services.

"It says a lot about stigma that people who are more enlightened about mental health, still see being open about their problems as a barrier to career progression."

Confidentiality

The responses suggested such decisions appear most often to be based around concerns that personal information would not be kept confidential and the effect that could have on a doctor's career.

They also found 41% of respondents would seek informal medical advice, but 8% would either self-medicate or opt for no treatment at all. In all, 12.4% indicated that they had experienced a mental illness.

Dr Alfred White, consultant psychiatrist at Birmingham and Solihull Mental Health NHS Trust and one of the researchers, said the fact they had a 70% response rate from the initial 3,500 surveys suggested this was an important issue for doctors.

"Doctors who are reluctant to seek professional advice for mental health issues may be putting themselves, and possibly also their patients, at risk and we are concerned that there are a lack of options for doctors who feel they are mentally unwell.

He added: "Doctors suffer higher levels for depression and substance misuse, as well as higher rates of suicide than the general population.

"The apparent lack of confidence in the current system protecting doctors' confidentiality may exacerbate these trends."

Paul Farmer, chief executive of mental health charity Mind, said: "Many people are afraid to disclose their mental health problems in the workplace for fear that they will be seen as 'weak' or 'less capable' than others.

"Doctors work long hours under extreme pressure, and it's important that they feel they can seek medical support when they need it, just like anyone else."

A spokeswoman for the British Medical Association said the findings backed up their own research, which suggested that as well as confidentiality, many worry that admitting to mental health problems could be a barrier to career progression.

"What we need is culture change to battle the stigma of mental illness.

"Doctors should feel free to seek help from the NHS rather than think they need to hide what they're going through."

A spokeswoman for mental health charity Rethink said: "The fact that stigma remains strong among doctors - professionals who by definition should know that mental health problems can affect anyone at any time - shows just how entrenched the prejudice is."

Mental Health Intervention Team announced as permanent component of NSW Police Force

Wednesday, 05 Aug 2009 05:30am NSW Police Media release

A two-year pilot program addressing the NSW Police Force's response to people with a mental illness or mental disorder and related issues has concluded, with the program and training now to be rolled out across the State.

Deputy Commissioner - Field Operations, Dave Owens will this week announce the formation of the Mental Health Intervention Team (MHIT) as a permanent component of the NSW Police Force Policy and Programs Command.

The NSW Police Mental Health Intervention Team is a program initiated by the NSW Police Force, in conjunction with NSW Health, to assist frontline police in interactions with members of the public with mental health issues.

NSW Health supported the trial by funding the secondment of a senior mental health clinician to provide advice on the overall program design, content expertise in the training program design and to provide organisational linkage between the MHIT and health setting service providers.

The MHIT program was commenced as a two year pilot program on 1 July 2007 and the team, in consultation with various mental health experts, developed an intensive four day MHIT training course which includes delivery of specialised mental health training (with emphasis on de-escalation and communication skill

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development) to manage those experiencing a mental health emergency event. The training was delivered to 40 officers from each of three Local Area Commands at Eastern Beaches, Penrith and Tuggerah Lakes.

An ongoing independent evaluation of the MHIT by Charles Sturt University has highlighted positive results for police including; greater confidence when interacting with mental health consumers, a reduced risk of injury to police and community members, and improved interagency relations between mental health stakeholders as well as improving outcomes for people with mental health problems who come into contact with police.

The Commissioners Executive Team of the NSW Police Force has now set a training target for the MHIT of a minimum of 10 percent of all frontline officers trained in the four day Mental Health Intervention Officers Course over the next five years. Approximately 300 officers per year will be undertaking the training. NSW Health will continue to support the MHIT by funding the mental health clinician position for a further three years.

Deputy Commissioner Owens said that "Every day police across the state deal with mental health consumers and respond to mental health related incidents. This can present challenges and sometimes these incidents become time-consuming and can place police and others at risk.

"The training we are delivering will provide frontline police with the skills to efficiently and effectively deal with mental health consumers, as well as provide support to partner agencies," he said.

NSW Health's Deputy Director-General Strategic Development, Dr Richard Matthews "NSW Health is proud to have been actively involved in the development of the Mental Health Intervention Team. NSW Health and NSW Police have a strong history of partnership, and will continue to work closely to ensure people with mental health problems get the care they need.

Hello "Triple Zero (000)

For most of us, the number to contact emergency services has always been referred to as "Triple 0".

This terminology seems to have always been with us, dating back to the days when phones had rotary dials and Don Lane was on the telly late at night.

The arrival of alpha/numeric phone keypads has seen the creation of many new marketing opportunities, so while a phone number in the past was just that - numbers, these days ordering some take away is as simple as dialing 13PIZZA.

Suddenly there is the very real risk of people, who may have never needed to contact emergency services before, making a dialling error during a crisis.

Using the alpha/numeric style of dialing and simply mistaking '0' as the letter 'O', the potential exists for people to dial "666" and that phone call is never going to make an ambulance appear in the driveway.

So for these very good reasons, the Ambulance Service of NSW (and all other emergency services across Australia) have agreed to move to a new way of describing our emergency contact number "Triple Zero (000)".

As members of the health system we can lead the way as we introduce "Triple Zero (000)" into all our communications - when we talk to kids, our community, our patients, reminding everyone that the only way to call for help is to dial "Triple Zero (000)".
So, it's goodbye "Triple 0" and hello "Triple Zero (000)".

Lesley Burrett

National Prescribing Service Limited

Quality use of medicines with Antibiotics

Health professionals are being given clear guidelines for prescribing particular antibiotics in different diagnostic scenarios in the latest National Prescribing Service (NPS) education program, *Management of specific respiratory tract infections*.

The therapeutic program reinforces the following: Antibiotics are only appropriate in acute cough if a chest X-ray suggests pneumonia or in exacerbations of chronic obstructive pulmonary disease (COPD) with sputum purulence, plus increased sputum volume and/or dyspnoea

- Antibiotics are only appropriate in sore throat if all four diagnostic criteria (fever, exudate, lymphadenopathy and absence of cough) for streptococcal infection are present
- Use penicillin V for 10 days in uncomplicated sore throat that appears to be streptococcal
- Reserve macrolides when treating respiratory tract infections for those with pertussis or those hypersensitive to penicillin
- Cough and cold medicines have limited efficacy
- Provide advice to patients on appropriate symptomatic relief

As part of the therapeutic program, NPS provides health professionals with:

- **Case study (58):** *Antibiotics and respiratory tract illness – thinking of patient-centred care*
- **GP Clinical Audit:** *Management of specific respiratory tract infections* **(enrol by 7 August 2009)**
- **Prescribing Practice Review (46):** *Management of specific respiratory tract infections*
- **NPS News (63):** *Managing expectations for antibiotics in respiratory tract infections*

The GP clinical audit is recognised by the RACGP Quality Assurance & Continuing Professional Development Program, total points 40 (category 1) and in the ACRRM Professional Development Program, 30 points (extended skills). It also qualifies as an activity for QPI of the PIP (Quality Prescribing Initiative of the Practice Incentives Program), year ending April 2010.

To enrol in the clinical audit visit www.nps.org.au/health_professionals.

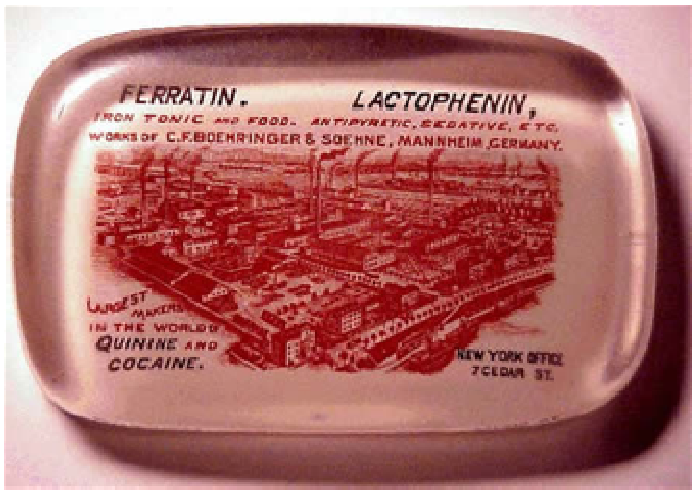
For more information contact NPS on (02) 8217 8700 or email info@nps.org.au.
For more information on the program contact:
Lesley Burrett 6583 3600

The National Prescribing Service Limited (NPS) is an independent, non-profit organisation for Quality Use of Medicines funded by the Australian Government Department of Health and Ageing.

INTERESTING MEDICATIONS FROM THE PAST

A paper weight

A paper weight promoting C.F. Boehringer & Soehne (Mannheim , Germany). They were proud of being the biggest producers in the world of products containing Quinine and Cocaine.



Do your Patients need Accommodation?

ROTARY LODGE provides low cost motel accommodation based in the grounds of the Port Macquarie Base Hospital. Accommodation is available to anybody who is receiving health related treatment or has health related appointments in the Hastings area.

The rooms at Rotary Lodge contain a bathroom, kitchenette, microwave, TV, tea & coffee facilities. Crockery and linen is also provided. The accommodation fees are charged as per IPTAAS assistance-$33 for one person per night, additional Adults $13/Children $10 each.

If you would like to book or refer a patient to the lodge our phone number is 02 65811076. Office hours 8.30am to 3 pm Monday to Friday.

THICKENED DRINKS? Yuck!

Just give me some colgate!

Hands up all who'd like a nice big glass of thickened water? No? what about some nice thick coffee? (and I don't mean Turkish ...)

For those patients who are experiencing swallowing difficulties, one of the most difficult management issues for speech pathologists has been their fluids. Whether due to poor oral control, uncoordination or a degree of dementia, there have always been those who need their drinks 'thickened up' to give them more time to bring their own protective reflexes into play and reduce the risk of aspiration. This has given rise to its own problems however, including poor compliance and therefore increased risk of dehydration.

Well .... The good news is that research in rehabilitation facilities around the world is showing that in many cases, it is preferable to continue with normal drinks. This can only be determined through full assessment by a speech pathologist experienced in dysphagia (there will always be those patients for whom it won't work) and also requires that each health facility has in place, a strict oral hygiene programme, as poor oral hygiene has been shown to be a greater contributor to aspiration pneumonia than the provision of thin fluids. In fact, a rehabilitation facility in Japan with a great oral hygiene programme, has consistently returned an aspiration pneumonia rate of 1% or below in its patients!

Imagine the benefits:

- Your patients (and their families) will be much happier;
- Decreased risk of dehydration (and the other health problems which accompany it);
- Water does not in and of itself produce bacteria as thickened fluids may do if aspirated.

So get your patients assessed today!

Karen Stevens
Nursing home and clinic visits
DVA provider
20 years experience
Freedom of Speech
40 Table Street
Port Macquarie