

### *Refugee Health Forum an Outstanding Success*

The Division and Southern Health held a Refugee Health Forum on June 20<sup>th</sup> in recognition of World Refugee Day. The forum was attended by 130 people from a broad range of primary and acute health services, community services and other organisations. Speakers included: Mr Yien Thiang Louny (Sudanese community rep), Ms Mary Rydberg (South East Health Communities Partnership/ City of Greater Dandenong), Dr Chris Drummond (Infectious Diseases physician, Southern Health/WHO & Red Cross), Professor Sandy Gifford (Director – Refugee Health Research Centre, La Trobe University), Ms Roslyn Leary (Regional Manager, Foundation House), Dr Chris Lemoh (Infectious Diseases physician, Royal Melbourne Hospital), Dr Georgia Paxton (Paediatrician, Royal Children's Hospital) and Ms Annette Dupont (Program Coordinator, General Practice Divisions – Victoria).

The forum, developed on the theme "Refugee Health – Making the Links", aimed to build on a similar event held last August and demonstrated the continuing health needs of this sector of the community as well as advances that have been made in service provision over the past year.

Our speakers covered a range of matters, with highlights including a graphic and compelling presentation by Dr Drummond showing conditions in refugee camps in a number of countries in which she has worked with Medicine Sans Frontieres, Red Cross and WHO. A theme common to a number of the presentations is that combined, the social, cultural and geographic factors leading to people becoming refugees, compounded by physical and mental conditions of circumstance, means that those people 'lucky' enough to arrive in Australia will almost universally require significant ongoing medical and psychological support.

Professor Gifford pointed to a current longitudinal study charting the experiences of young people arriving in Australia. In the first year of the study it was found that young people have high aspirations and high self confidence (both despite and because of their life experiences to date). However, in the third year of this five year study, these characteristics remain intact but the social impacts of relocation, experiences of racism in this country and inter-generational/family/cultural identification issues are having a negative effect on the lives of young people.

Other health concerns discussed included the prevalence of specific conditions (e.g. tuberculosis, vitamin D deficiency) and the necessity for our health system to be able to compensate for the lack of health services in the countries of origin. Problems with ineffective screening processes and lack of immunisation mean that health services in this country have to "pick up" or "start over" in order to ensure good health in our communities.

It is clear that in the past few years the numbers of refugees in our community has increased and that the range of health problems has broadened. However, it is also clear that knowledge, expertise and responsiveness in the service system have developed proportionally. In March this year Southern Health, supported by the Division, established a Refugee Health Clinic, which is conducted each Monday afternoon at Dandenong Hospital Outpatients. This clinic receives referrals from GPs and is supported by an infectious diseases specialist, paediatrician, consultant psychiatry, Refugee Health Nurse and attending GPs.

So, what more can GPs do? Annette Dupont (GPDV) advised the forum that a template for the Refugee Health Assessment (MBS item 714/716) is almost completed and will be launched in September (including an electronic version). Further, Foundation House has revised and updated their *Refugee Health and General Practice* booklet and companion desk top guide. Or you might like to gain more 'hands-on' experience by joining the roster for GPs working at the Refugee Health Clinic. I would be happy to provide more information about these initiatives on request.



Full house – standing room only as 130 people attended the Refugee Health Forum at Dandenong Hospital Lecture Theatre

## *Dandenong District Division of General Practice*

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*Deadline for newsletter articles is 10<sup>th</sup> of each month. Dandenong District Division of General Practice reserves the right to accept or reject all material submitted for publication. For further information please call the Division.*

#### **DISCLAIMER**

*The views expressed in this newsletter are those of the authors and do not necessarily reflect the official position of the Dandenong District Division of General Practice*

**Inserts: Anxiety/Depression, Alcohol and Drug Problems**



The Practice Managers and Nurses taking it all in

## **practice managers and nurses conference 2007**

The Dandenong Division in conjunction with Greater South Eastern Division held its first annual Practice Managers and Nurses conference. It was held on 15<sup>th</sup> June at The Country Place Retreat in Kalorama. The conference was an outstanding success. The guest speakers included Deivina Peethamparam from Macpherson and Kelley, the team from Acacia Learning Solutions, Dr Robert Walters from MIPS, Paul Beaver from Key Skills and Mick Rodgers from Southern Health. Their individual presentations were enlightening and extremely informative. The feedback we have had from those who attended has been overwhelmingly positive.

The highlight of the day was the Friday night dinner with entertainment provided by The Horny Toads. This was a great opportunity for everyone to enjoy a delicious meal, taste the fabulous wine, practice the “flying goose!” and network with other Practice Managers and Nurses.

We would like to send a huge thank you to the working party for their valuable contribution to the conference, including Julie Shanahan, Kate Russo, Rose Griffiths, Stephanie Edmonds and also Chris Edmonds and Liz Senior from Greater South Eastern Division.



From left to right: Lesley Flannery, Stephanie Relph, Bev Robinson, Karen Welsh, Barbara Renda and Kate Russo

More photos from the day can be found on our website [www.dddgp.com.au](http://www.dddgp.com.au)

# Immunisation News

**The HPV Program for GP:** All practices should have received a letter from the Department of Human Services regarding the human papillomavirus vaccine, included with the letter was an order form. The letter highlighted that GPs will not receive the HPV vaccine until mid July and practices will be required to complete 2 questions on the vaccine order form.

1. You will need to advise DHS of how many girls between 18-26yrs of age you have at your practice. This can be done via your practice software or by an estimate of the number in this age group.

2. Is your practice intending to run HPV immunisation clinics?

Resources, including a mail out letter template for inviting all your female patients between 18-26 years of age should have been sent each practice.

**The HPV Register** - A specific register will be set up to capture the data on HPV vaccinations from all providers and will be operational later this year.

From July 2007 GPs will be asked to record all relevant information concerning the provision of HPV vaccines to all girls who are under 18 years of age and not at school. They will be asked to load this information onto the proposed HPV Register when it is in operation. GPs will be entitled to a \$6.00 payment for lodging the data on the register for each of the vaccines given. GPs are encouraged to record the data concerning women between the ages of 18 and 26. This will provide a good record to enable recalls for the subsequent 2 vaccinations and eventually provide the women with long term information about their immunisation status. There will be no payment for submitting this data but GPs are encouraged to add this data to the register if at all possible. It is hoped that this HPV register will become part of the proposed 'Whole of Life Register' and will provide both the patient and GP with an excellent ongoing record of the vaccinations received at a particular time.

**Immunisation Tip: MMR Shortage** - A reminder that Victoria is facing a shortage of the MMR vaccine. DHS cautions practices not to order too many vaccines and to be vigilant with cold chain management. For more information or cold assistance please contact Kate at the Division.

**Measles alert for travellers to and from Japan** - GPs are being advised of a measles outbreak in Japan and requested to be vigilant for symptoms of measles in visitors and returning travellers from Japan. To help protect Australians travelling abroad an "[Advice to travellers visiting measles endemic areas](#)" sheet should be provided to people wishing to visit Japan during the current measles outbreak. Also available is a

[Measles: Background Information](#) sheet which is an extract from the 9th Edition Australian Immunisation Handbook

## Background

An outbreak of measles originated in Tokyo in February 2007 and has spread through central and northern Japan. Over 1000 cases have been reported in Japan this year and the number of new cases is continuing to rise. The current outbreak in Japan is not confined to only children. A third of the reported cases are aged 15 years old or above. Taiwan and the United States have both reported cases of measles imported from Japan. Although single dose measles vaccine has been used in Japan for many years, the routine use of a second booster dose was only introduced in 2006 for primary school children. Japanese people of secondary school age and older will not therefore have routinely received two doses of measles vaccine. Low second dose vaccine coverage rates may be contributing to the current outbreak in Japan. Authorities in Japan are actively managing this outbreak, increased surveillance is in place and community vaccination campaigns have begun.

## Need for increased vigilance in Australia

Measles has been essentially eradicated in Australia. In 2007, Australia reported only 11 cases of measles and most of these were associated with overseas travel. Australia maintains very high measles vaccination rates, with 93.6% coverage in 24-27 month-old children and 88.9% in 72-75 month-olds (31 March 2007 figures).

However, measles still poses a threat to certain population groups in Australia, and the early detection and management of suspected measles cases is required to ensure that local transmission does not occur. The current outbreak in Japan and its close proximity to Australia increases the need for vigilance for symptoms of measles particularly in visitors, of all ages, from Japan and those returning from visits in Japan. A list of other countries with high prevalence of measles is provided for your general information. As a notifiable disease, all suspected cases of measles should be reported to your local health authority. To report an outbreak call the number to call is 1300 651 160.

**MARK THIS DATE IN  
YOUR DIARY NOW!**

## **DANDENONG DIVISION AGM**

The Dandenong Division AGM will be held on Wednesday 21<sup>st</sup> November at the Southern Golf Club, Keysborough. Make sure you keep this date free!

## Congratulations

Mr Chris Yugusuk, Refugee Health Worker at CDM St Damian Medical Clinic – Dandenong, was awarded a Victorian Refugee Recognition Record at a Victorian Multicultural Commission Refugee Week ceremony on Sunday June 17<sup>th</sup>. Chris is currently studying social work and also provides a support role for the Refugee Health Clinic at Dandenong Hospital.

The VRRR is an official recognition by the Victorian Government acknowledging the achievements and contributions of refugees to their own and broader communities.

The Division is pleased to offer our congratulations to Chris for his award.



Mr Chris Yugusuk, Refugee Health Worker (centre) receiving a Victorian Refugee Recognition Record with Ms Shirley Blackwood (practice manager, left) and Dr Janet Gross at CDM St Damian Medical Clinic, Dandenong.



### Young GPs Interest Group

You are invited to join the next meeting of the Young GPs Interest Group. This group has been convened by Dr Brett Ogilvie, especially for GPs who have been working in general practice for less than ten years.

Meetings are held at a local restaurant providing a relaxed informal environment for participants to get to know each other and discuss anything from interesting clinical cases to difficult situations in general practice and rewarding experiences.

The idea for establishing such a group has come from the component of GP Registrar training where participants attend a "release forum" to get away and de-brief with a small group of 8-10 colleagues.

To date, this group has met twice and the next meeting will be held on Thursday 26<sup>th</sup> July at 7.30pm at a local restaurant in Berwick. To express interest in attending this meeting, please contact Julie Sutherland on 9706 7311.

## Kidney Disease No Warning Signs Early Detection at GP Level Key to Control Kidney Disease

Kidney Health Australia today said the spiralling kidney disease numbers in Australia need to be addressed with a concerted effort by General Practitioners of targeted opportunistic early detection of people in high-risk groups.

Over 40 people die each and every day from kidney failure in Australia.

Kidney Health Australia CEO Anne Wilson said, "Research showing that over 25% of all patients coming to dialysis and transplantation do not see a kidney specialist until less than 90 days before dialysis starts, is a clear indication of the need for a national GP Kidney Disease screening program".

"Overseas and local programs indicate that the pick-up rate of Chronic Kidney Disease (CKD) in a program targeted at high risk individuals is about 50%."

"It is only necessary to perform simple tests such as a urine test for albuminuria, blood test for creatinine and sugar and a blood pressure measurement".

"These are non invasive tests and if a problem is identified it can be treated and managed well before a person is forced onto dialysis to continue to survive," Ms Wilson said.

Latest Australian economic data show that an annual GP-based opportunistic screening of 50 to 69 year-olds and intensive management of screen-detected patients with diabetes, high blood pressure or protein in the urine is likely to be a cost-effective strategy for preventing kidney failure and cardiovascular morbidity and mortality.

"The cost of treating kidney disease in Australia is rising by \$50 million a year and will jump from \$700 million in 2006 to \$900 million in 2010, according to the first ever report on *The Economic Impact of Kidney Disease* in Australia released earlier this year."

"There is considerable evidence that CKD is not being adequately detected or appropriately managed by primary health care providers in Australia".

"Even in people with known diabetes, important kidney function tests are not performed despite overwhelming evidence that such an approach is essential to facilitate best practice care plans."

The best-available evidence supports a strategy for the control of CKD through early detection and intensive management of three risk factors for CKD and for its progression - diabetes, high blood pressure and protein in the urine, Ms Wilson said.

At the present time there are no programs in primary care in Australia systematically detecting CKD.

## Commonly asked questions about Gardasil



**If the spacing between the vaccines is longer than recommended in the product information (0, 2 & 6m) does the person need to start the course again?**

No. Where there has been a delay between doses of GARDASIL® it is expected that the course continue as recommended. There is no need to re-start.

**Can women who are breastfeeding have the HPV vaccine?**

Yes. Breastfeeding is not a contraindication to GARDASIL® however pregnancy is.

**What advice do you give to women who want the GARDASIL® vaccine but are planning to become pregnant?**

It is recommended for females to complete the course (three doses) prior to planning pregnancy. HPV vaccine should not be given during pregnancy. Where vaccine has inadvertently been administered during pregnancy, further doses should be deferred until after delivery.

**What if a person is exposed to HPV between doses?**

Exposure to any of the four HPV types covered by the vaccine before the three doses are completed may lessen the effect of the vaccine.

**Are booster doses of HPV vaccine required?**

Not at this point in time. Research to date has demonstrated protective immunity for at least five years and there is no indication currently that boosters are needed. Clinical trials are continuing and the results will be monitored to determine whether booster doses will be needed in the future.

**Is HPV vaccine available for women older than 26 years?**

Not at this time. Older females are likely to have had more exposure to HPV, so the benefits of HPV vaccine may be reduced. Clinical trials into the benefits of the vaccine for women older than 26 years continue.

**Can councils immunise females who are aged 18-26 years?**

Yes, after July 2007. Councils would be able to administer the vaccine to 18 - 26 year old females if they wish to do so.

**Are Pap smears required after vaccination against HPV?**

Yes. The HPV vaccine does not protect against all HPV types that can cause cervical cancer. All females aged 18–69 who have ever been sexually active, whether vaccinated against HPV or not, should have regular Pap smears as

recommended. Pap smears detect abnormal changes to cells in the cervix so treatment can start before cancer develops.

**Sources:**

National Centre for Immunisation Research and Surveillance (NCIRS)

Immunise Australia Program, Department of Health & Ageing, Australian Government

Cancer Council, Victoria



integrity • compassion • accountability • respect • excellence

Better Health for Our Community

### GP Liaison Unit Update – June 2007

#### **GP Liaison Units Annual GP Survey**

The GP Liaison Unit's Annual Survey is currently being distributed. Be sure to keep an eye out for it. This is your chance to contribute any comments and influence our workplan over the coming year. If you have any queries regarding this survey please don't hesitate to contact us.

#### **Human Services Directory – Add your Provider Number**

The Human Services Directory (HSD) is the database used by most Victorian Hospitals to obtain GP contact details. If your details are not up to date on the HSD, or have never been added, this may be the reason why you are not receiving information.

**Please Note:** Don't forget to add your provider number to your details. This is the key way Health Services who use or are moving towards electronic discharge summaries and notifications are able to identify individual GPs.

Please have your Practice Manager check the HSD – [www.humanservicesdirectory.vic.gov.au](http://www.humanservicesdirectory.vic.gov.au) to verify and/or add your details.

#### **Acknowledgement**

Southern Health's GP Liaison team would like to acknowledge the enormous support, encouragement and advocacy of Dr Peter Waxman. Peter's influence at a strategic level within DHS has assisted us greatly in our work at the GP-Hospital interface. He will be sadly missed.

#### **Contact Us**

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**Antibiotics ..... wonder drugs! ..... I wonder what my patients do with them?** Well some won't even take them. There was a nice little study conducted in Melbourne in February 2000<sup>1</sup> in which 1298 women were surveyed re their experiences with antibiotics and post antibiotic vulvovaginitis (PAV) which found that about 1 in 4 women taking antibiotics had experienced PAV, that as a result about 1 in 3 of these women were concerned about taking antibiotics, that 1 in 5 would not take antibiotics and of these 1 in 5 would not tell their doctor they were not taking their antibiotics.

Of course sometimes patients commence a course of antibiotics and never finish them e.g. the author of this article who was put on metronidazole but decided not to finish the course as the party on Saturday night was more important. (Actually as it turns out metronidazole + alcohol may not be a problem. Apparently a group of medical students volunteered to try the combination and experienced no ill effects. This only goes to show the courage of the young men and women who dedicate themselves to medicine.) Others do not finish the course of antibiotics because of adverse reactions – diarrhoea, rash, nausea etc. – the drug being nastier than the disease in many cases. And these adverse reactions are common. In one study re: the antibiotic treatment of acute otitis media, diarrhoea occurred in about 1 in 6 patients and rash in about 1 in 50. Unfortunately, with antibiotics the adverse reactions are so common that most health professionals just discount them as a normal reaction to the antibiotic: “don't worry you'll get over it when you finish the antibiotic”. Not bad advice except that in most cases they were going to get over the infection anyway.

So what happens in the world of general practice to these patients who don't take their antibiotics or stop antibiotics early? Probably not much. If their condition is self limiting, by the time they stop taking antibiotics they will be a couple of days closer to resolution and if not they will return to the GP. There may even be a benefit as stopping the antibiotics early helps to prevent the development of resistant organisms (if the antibiotic was given in an appropriate adequate dose in the first place) by reducing selection pressure. Another benefit may be likened to an “ethnic cleansing”, in that antibiotics can cause an unbalance of the bacterial/fungal population of the human body and subsequently a “war” ensues as the remaining populations fight to recolonise the space. Of course, normally, the wider the spectrum of the antibiotic the worse the war. Two examples of this are the promotion of fungal infections (oral and vaginal thrush – the

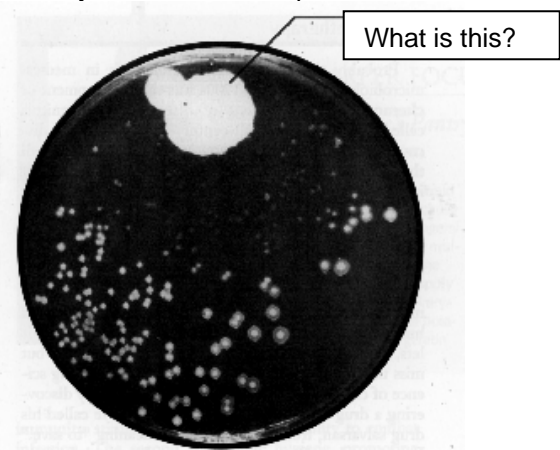
6  
less serious end of the spectrum) and pseudomembranous colitis (super-infection of *clostridium difficile*, occasionally fatal – the serious end of the spectrum) which are both more likely with longer antibiotic use.

This explains why the therapeutic guidelines seem to be heading in shorter courses of antibiotics. With a narrower spectrum at higher doses, it's not just to aid compliance but to reduce adverse effects and bacterial resistance both in individuals and for populations. But this trend is also associated with a trend to aid compliance by giving fewer but higher daily doses and this in itself may be causing adverse events. For example it has been reported that amoxicillin 1g bd may cause more diarrhoea than amoxicillin 500mg tds.

1."Not thrush again!" Women's experience of post-antibiotic vulvovaginitis MJA 2003: 179(1):43-46

### Quick Quiz.

1. Why is this picture famous?



2. Reduction of visceral fat with liposuction may be a promising method for the prevention obesity related progression to type 2 diabetes. True or false?
3. Why are antibiotics about equally useful for the treatment of bacterial and viral acute bronchitis?
4. Codeine is an effective analgesic in persistent pain due to it's long duration of action. True or false?
5. Antibiotics are recommended in all mammalian bite wounds which present more than 8 hours after the injury. True or false?

### Immunisation Tip



There have been reported cases of chickenpox around Melbourne, remember that all children born since May 1st 2004 are eligible for funded chickenpox vaccine once they are 18months old. There is also a catch up program for children in Year 7. Sometimes they just need a reminder.

## Multilingual cancer information on the internet

Did you know you can access patient information about cancer in 17 different languages on The Cancer Council Victoria's website?

The information is provided as easy to read factsheets that can be downloaded free of charge. Topics vary from diagnosis and support, to early detection messages, and information on different cancer types. English versions of all factsheets are also available.

Look out for a card promoting the multilingual website that is being sent to all GPs in June.

Visit the website at [www.cancervic.org.au/multilingual](http://www.cancervic.org.au/multilingual) to download this information for your patients and your practice



South East Healthy Communities  
Partnership  
Interagency Care Planning Project

### BACKGROUND

Across Victoria many people who use a range of health and community services have said that there is no real coordination between the services.

To try to overcome this South East Healthy Communities Partnership has funded a project to develop and trial an Interagency Care Plan Protocol. A working group comprising community based service providers and GP Division staff in Greater Dandenong, Casey and Cardinia has drafted a protocol designed to support improved service coordination.

### HOW WILL IT WORK?

Service Providers\* will invite clients with complex needs using more than three services, and who may benefit from an interagency care plan, to be involved in the trial of the protocol. Once clients have agreed to be involved (and consented to their information being shared between providers) their GP will be invited by the clients case manager or worker to take part in a case conference which may be in person, by phone or by providing written information to develop the interagency care plan.

At the case conference, the GP may choose to undertake a GP Management Plan (MBS Item 721) and/or Team Care Arrangement (MBS Item 723). If, as a consequence of the case conference, the GP undertakes a 723, then it is understood that they will liaise with the patient and provider to complete the "Team Care Arrangement."

Alternatively, the GP may choose to contribute to the care plan developed by another provider (MBS Item 729). If the GP does not undertake either a GPMP or TCA, they may still claim the relevant "participation in a community-based case conference" item (Items 759, 762, or 765).

### WHAT HAPPENS NEXT?

After the trial period (May-September) if you have been involved your feedback will be sought and

used to improve the protocol before it is used more widely in the South East.

\* Typically, such contacts would come from Case Managers from Bunurong Community care, Local Government HACC services, HARP Care Coordinators, Community Health Nurses, RDNS.

### Contact:

**Julie Sutherland Dandenong and District Division of General Practice ph 9706 7311**

**Lisa Paulin Eastern Ranges GP Association ph 9739 6751**

**Heather Lawson for South East Healthy Communities Partnership ph 9645 1499**



Royal District Nursing Service (RDNS) provides professional nursing and healthcare to people in their homes, enabling them greater choice and independence. The majority of RDNS' clients are the frail, elderly or disabled.

RDNS nurses provide the following care, tailored to individual needs: aged care, technical nursing care, continence, cystic fibrosis, diabetes, HIV/AIDS, palliative care, stomal therapy, wound care, and a 24-hour telephone advice service for admitted clients.

RDNS nurses are committed to on-going communication and consultation with clients' General Practitioners. It is by working collaboratively with GPs that we are able to enhance clients' care.

Call 9536 5222 for more information about an RDNS centre close to your practice.  
[www.rdns.com.au](http://www.rdns.com.au)

## australian posttraumatic stress disorder guidelines launched

Australian guidelines are now available to help people with acute stress disorder and posttraumatic stress disorder (ASD and PTSD).

*The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder (ASD and PTSD)* were launched on 23 May by the Minister for Veterans' Affairs, the Honourable Bruce Billson, MP, at Parliament House, Canberra.

Approved by the National Medical Health and Research Council, these new Guidelines assist health practitioners to determine when is the right time for professional intervention and what's the best approach for helping people affected by trauma.

The Australian Centre for Posttraumatic Mental Health developed the Guidelines in consultation with trauma experts from a range of disciplines, as well as people affected by trauma. Visit [www.acpmh.unimelb.edu.au](http://www.acpmh.unimelb.edu.au) to download copies.

## Employment Agreements and Australian Workplace Agreements

Over the past month the Division has held two workshops facilitated by Macpherson & Kelley Lawyers. The Division in consultation with Macpherson & Kelley has negotiated generic AWA and Employment Agreements. These agreements can be made specific to your circumstances. To enable access to these, members within our postcode boundaries would need to attend a workshop held here at the Division. Depending on further interest, future workshops will be organised.

The past two workshops have been very well attended, very informative and delegates have gained much insight into the Workchoices Legislation and the Health & Allied Services Private Sector Award, which are both relevant to general practices.

It is unwise and unadvisable to try and implement these types of agreements without professional advice. The legislation is tedious, complicated and changing constantly. There are items which are mandatory and items which are prohibited. Also, if appropriate, an "all inclusive" hourly rate for employees can be formulated.

Further information can be obtained by contacting Julie Shanahan – Business Coordinator at the Division on 9706 7311.

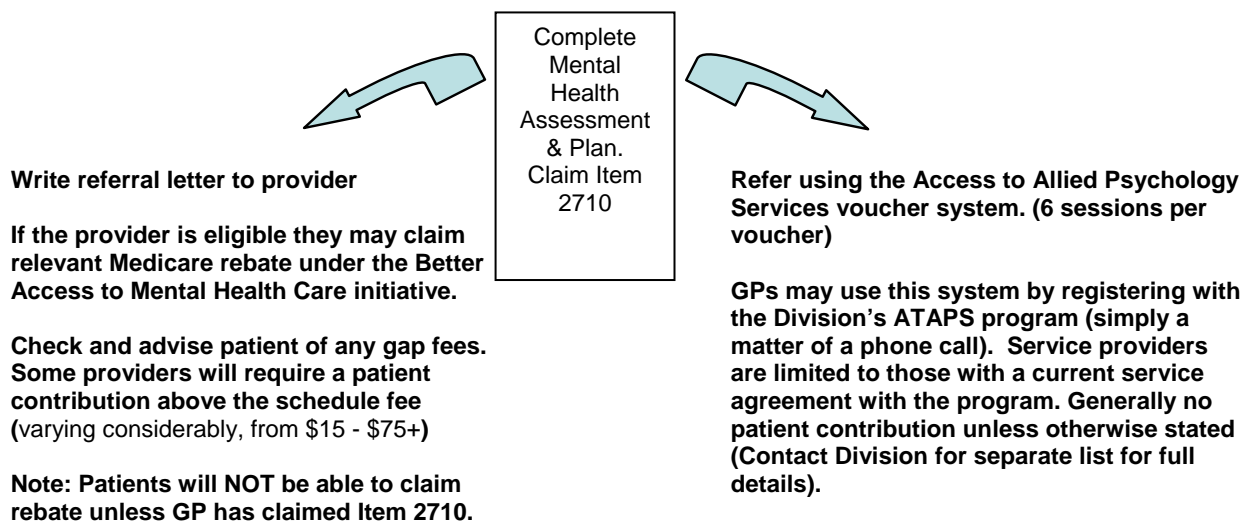
## QUM news - Quick Quiz Answers.

1. This picture is famous because it is the show the agar dish on which Alexander Flemming noticed that a mould growth prevented bacterial colonies from growing, it is the picture on the front of the Antibiotic therapeutic guidelines.
2. False. Liposuction removes subcutaneous abdominal fat and does not improve insulin sensitivity.
3. Because antibiotics do nothing for the treatment of viral acute bronchitis and the small reduction in symptoms (about half a day of reduced cough) that occurs with bacterial acute bronchitis is counterbalanced by adverse events that may be caused by antibiotics (e.g. vaginal thrush 1 in 4, diarrhoea 1 in 5 etc).
4. False. The duration of action is about 3 to 4 hours for those who can metabolise it to its active metabolite i.e. morphine. Note about 5 to 10% of Caucasians, 1 to 2% of Asians and 1% Arabic people cannot metabolise codeine.
5. True as such wounds have a high chance of being infected. (Therapeutic guidelines antibiotic).

### PSYCHOLOGY REFERRALS MADE EASY

There has been a lot of confusion about referring to psychologists since the introduction of the new item number in November last year. AT IT'S VERY SIMPLEST:

Previously, only GPs registered for the Access to Allied Psychology Services initiative could refer using our voucher system. This program is still funded, but now there is NO prior training requirement to participate. This means that now ALL GPs have two pathways available for referring Health Care Card/Low income patients for psychological services.



N.B Number of vouchers available per year limited by program budget