Issue 2: General Practice July 2015

The Pulse

Newsletter of the Deakin Medical Student Society

General Practice

Editor's Notes

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2nd Year Medical Student

"The good physician treats the disease; the great physician treats the patient who has the disease". – William Osler

When it comes to clinical expertise, every GP has strengths and weaknesses. However, clinical prowess does not define an excellent doctor. Most of us will have experienced GP visits after which we vowed to never return again – because of lack of empathy, communication problems and so on.

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What then constitutes a good GP? What is it like to be one? To shadow one?

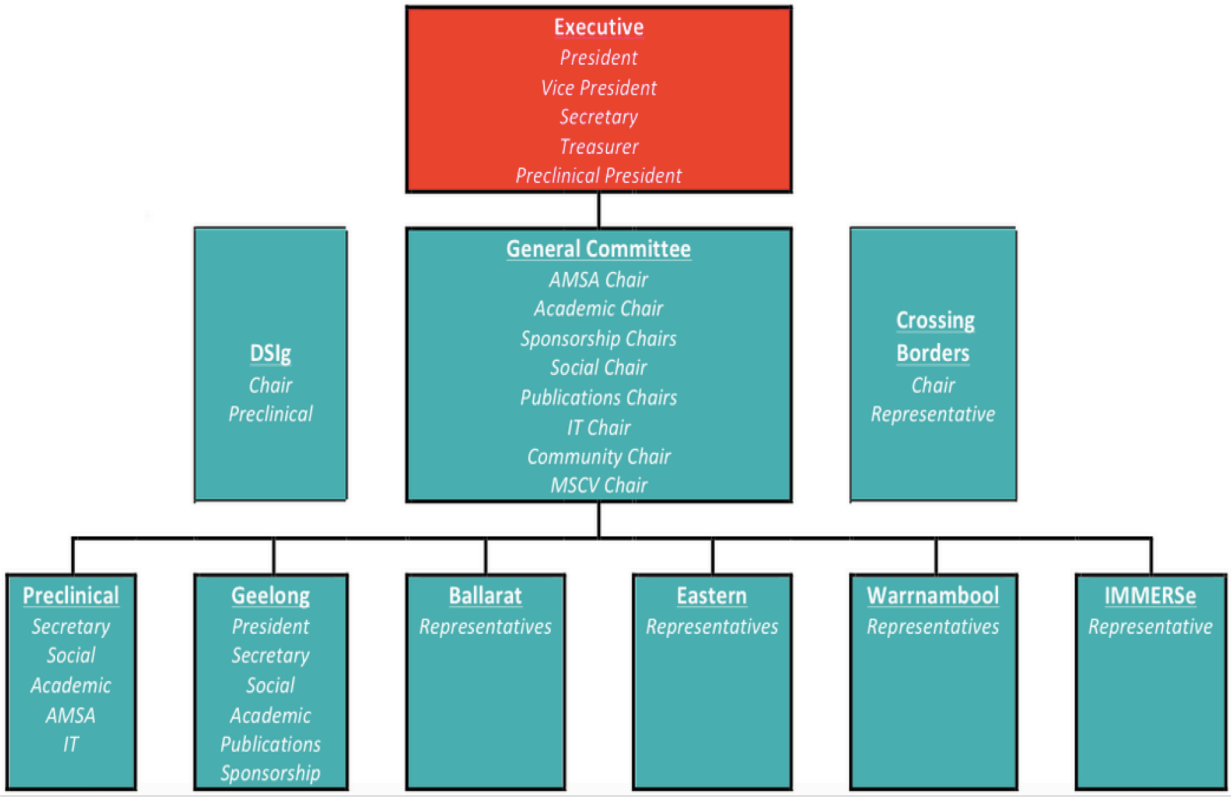
With this in mind, we bring to you personal experiences on GP mentoring, the John Flynn program, a GP placement, the 2015 Future of General Practice conference, as well as a special interview with Dr. Rosalie Cooper.

Whether you are an aspiring GP or wish to get as far away from physician-land as possible, we hope this collection of stories can provide you with some insight or guidance for your future medical career.

Thanks to all the wonderful people who contributed to this issue! I hope you enjoy.

The MeDUSA Committee Structure

The MeDUSA body consists of various committees. The Executive is made up of the President, Vice President, Secretary, Treasurer and Preclinical President. In addition, we have the General Committee, a Preclinical Committee, one for each clinical school site, as well as Crossing Borders and Deakin Surgical Interest Group. If you would like to get involved with MeDUSA in the future, make sure to look out for nominations for 2016 later in the year!



Rural Obstetrics and Gynaecology – a JFPP student perspective.

Jade Tregoweth

2nd Year Medical Student

From top, left to right: view from Port Douglas, QLD, in theatre scrubs at Cairns Private Hospital, view from Palm Cove, QLD.

I love Cairns – the never ending sugar cane fields, the tropical flora and fruits, the beaches and the laidback lifestyle. Cairns is an outer regional city, home to more than 150, 000 people and approximately 1, 700 kilometers (or 20 hours drive without toilet breaks) north of Brisbane. There was definitely no mistaking that I had stepped out of the plane and into a far north Queensland wet season as I arrived to commence a placement as part of the John Flynn Placement Program (JFPP) run by the Australian College of Rural and Remote Medicine.

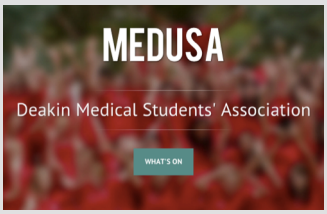
The JFPP aims to expose medical students to life in a rural community whilst providing positive mentorship with a rural practicing doctor in an attempt to attract more doctors to work rurally. As a female medical student, the importance of such a program has even broader implications.

The MeDUSA Website

MeDUSA has launched a new website, complete with a members-only section that is packed full of resources, including:

- Past exam feedback
- Practice exams
- Summary notes
- Clinical school information
- Sample timetables
- Internship information
- Useful websites/apps
- …and more!

So if you haven't yet, make sure to head over to www.medusa.org.au and sign up with your Deakin email address to check it all out!



New resources are continually being added. If you have any suggestions or contributions, please let us know!

Research has shown that greater than 70% of general practitioners (GPs) working in rural and remote locations are males[1] consequently, females residing in such areas are left at a disadvantage. For example, it is known that rural women are at increased risk of mortality from cervical cancer compared to women living in the city. If a town lacks a female GP, many women especially Australian Indigenous women may not access important preventative services such as pap smears. Initiatives such as the JFPP are important in encouraging more female doctors to work in the country. I would encourage anyone interested in becoming a John Flynn student or mentor to access the website[2].

I spent my placement with Dr. Thomas Wright, an extremely busy obstetrician and gynecologist who spends most of his time at the Cairns Private Hospital delivering babies. I was very excited at the opportunity to gain an insight into Obstetrics, based upon an unforgettable natural birth that I was privileged to observe in my previous life as a nursing student. I was very happy when Dr. Wright offered me the chance to start my first day in theatre for a planned cesarean section. It was an awesome experience and set the scene for a week of emotion-filled, often challenging experiences that I was about to be a part of under the thoughtful guidance of Dr. Wright.

I spent 12 busy and thoroughly enjoyable hours a day with Dr. Wright. The majority of our time was spent in his rooms as I observed antenatal appointments throughout all stages of pregnancy and the odd patient presenting with a gynecological problem. I observed many ultrasounds, amniocenteses, PV exams and pap smears, colposcopies and biopsies. Dr. Wright was a positive mentor and dedicated educator, including me in every aspect of the patient's history and examination, rationale for treatment, medical concerns and proposed outcomes. The highlight of my week was scrubbing in for cesarean sections where I was able to watch up close as a baby was assisted from its cramped world into ours.

It was an amazing week, although I do implore women considering a career in obstetrics and gynaecology to evaluate the impact upon your personal life, including relationships and family time. The days are long and there is no shortage of work during the nights, which if you do not maintain balance will take its toll. The up side is that it is the only medical specialty that allows you the opportunity to care for 3 or even 4 generations of women, from the foetus, to the mother, grandmother and possibly even the great, grandmother[3].

In addition, it allows you to provide care for a woman during all stages of her life - from neonate to post menopause and beyond[3]. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) offers various options for doctors, including a diploma (DRANZCOG) for GPs, an advanced DRANZCOG which is particularly useful for rural GPs, specialist training and subspecialty training. See the RANZCOG website for further information[3].

References:

1. Australian Rural and Remote Workforce Agencies Group (2003). ARRWAG Minimum Data Set Report – 30 November 2002. Canberra: ARRWAG.
2. The Australian College of Rural and Remote Medicine: John Flynn Placement Program. Accessible online at: https://www.acrrm.org.au/about-program
3. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (2005). Introduction the the practice of obstetrics and gynaecology. Victoria. RANZCOG. Accessible online at: https://www.ranzcog.edu.au/the-ranzcog/about-specialty.html

My GP Mentor

Elisa Pruss

2nd Year Medical Student

General Practice has been a term applied to a variety of meanings over the years - and my GP mentor has experience spanning the breadth of this dynamic profession. His diverse career has seen him perform surgeries and deliver babies in the context of rural General Practice, and I believe he has the best of the Murtagh era of General Practice to offer.

At a time when GPs were expected - as described in Murtagh's General Practice - to give marriage counsel alongside his prescriptions, vaccinations and management care plans, Dr Joe Di Stefano has patient relationships spanning the course of thirty years and has seen the Geelong region expand significantly since he began his small Leopold practice. He still practices there today.

Some of you may recognise Dr Di Stefano as one of the 2nd year DP tutors. It has been a tremendous privilege then, to be his medical student mentee. I have been able to frequent his consult rooms myself to observe his patient appointments and to assist in taking their histories and examinations. I have been fortunate enough to accompany Dr Di Stefano into his patients' homes when he made house calls. And even whilst doing so, I have been allowed to examine the abdomen of a child in his grandparents house when the home visit of an elderly couple became an impromptu paediatric consultation because that child visited with a stomach ache.

All of these experiences, I would not have had if I had not been lucky enough to be involved in the Barwon Medicare Local (BML) GP mentor program - which I am especially grateful for having come from a non-clinical background. The GP mentor program has also been of great worth to me on a personal level, when dealing with not making it through the second year OSCE hurdle. This trial has been made easier by having an doctor who was able to put it into the perspective of a greater medical career.

When I applied for the BML GP mentor program, I was hoping to give my medical degree some extra experience and a doctor whose wisdom I would benefit from - it has given me exactly that. I hope that in years to come the BML GP mentor program continues, even though the Medicare Local structure has been scrapped, as I have found it to be very valuable, and I know that some of my peers in the program have also found it rewarding

The Future of General Practice Conference 2015

Anna Cunliffe

4th Year Medical Student

The Future of General Practice conference 2015 (FGP15) was held during 22nd – 24th April at the fabulous Melbourne Convention and Exhibition Centre. This annual event attracted medical students, GP registrars and pre-vocational doctors from all corners of Australia, and for good reason. The three-day program included many outstanding speakers from diverse fields of medicine.

General Practitioners talked about interesting paths they had taken during their career; from working on *Australia's Embarrassing Bodies Down Under* television show (Dr. Brad McKay), to transforming a small, poorly remote health service into an extensive accredited health service now hosting regular rotating advanced emergency trainees and GP registrars (Dr. Samuel Goodwin). A highlight was the seminar by Professor John Murtagh on clinical reasoning.

Table 1: Murtagh's diagnostic model

1) What is the probable diagnosis?
2) What conditions must not be missed? - *Red flags or alarm symptoms* - *Vascular, infection (severe) or malignancy*
3) What are the pitfalls? - *Conditions that are often missed?*
4) Could it be one of the masquerades? - *Depression, diabetes, drugs/iatrogenic, thyroid/endocrine disorders, anaemia, spinal dysfunction, urinary tract infection*

During this session, Professor Murtagh discussed cases that had been difficult diagnoses, and stepped through his diagnostic model for clinical reasoning (Table 1 above).

In addition to General Practitioners, many specialists from other fields also presented interesting seminars. Dermatologist Dr. Alvin Chong presented two valuable lectures on detecting and managing skin cancers, focusing on the use of dermatoscopy in general practice. Associate Professor Neil Strathmore, cardiologist, presented a practical and informative workshop on ECG's for medical students.

Overall, the program at FGP15 was packed with stimulating sessions, often making it hard to choose which stream to attend. From a medical student perspective, the FGP15 conference was hugely beneficial as it covered a variety of different topics that are often not covered during medical school. It was a great opportunity for networking, and to gain an insight into the exciting and varied paths that a career in general practice can take you.

Professor John Murtagh presents at FGP15

What is the 'good GP'?

Nikolas Partsanis

1st Year Medical Student

The Royal Australian College of General Practitioners ('RACGP') recently launched 'The good GP never stops learning' campaign. It got me thinking – is there more to being 'the good GP' than alluded to in this campaign?

Patients have an expectation that doctors have the requisite medical knowledge, and doctors strive to build and expand that knowledge, particularly as treatment revolves around evidence-based medicine. However, it is the general practitioner who must transcend the boundaries of being a diagnostic tool and become an ear and even a friend, whilst maintaining the professional relationship of doctor-

For most of us general practice ('GP') is the first insight we have into the world of medicine. We do not remember our births, maybe some of us do (but that is a tale for another day). After speaking with family and friends about their GP they raised issues of doctor-patient rapport and communication, not the inadequacies of their medical knowledge.

This has been something that medical schools have become acutely aware of and have been attempting to address. On a placement earlier this year I shadowed (and I say shadow in very loose terms, because I was merely observing) a GP who had developed excellent rapport with his patients. This is where I want to start by describing some of the things that made this doctor, 'the good GP'.

Firstly, the GP spent a few minutes before each consultation briefing himself with the patient's file. This enabled him to quickly recall a patient's last visit and ask them if they had any further problems since that visit. It immediately demonstrated interest and concern about the person's wellbeing. In turn the patient seemed to be more open and willing to communicate.

He did not cast judgment, which was particularly important as many of his patients had substance abuse problems. Instead he

employed a harm minimisation philosophy that encouraged his patients to talk openly about their problems. I have no doubt that this is one of the defining and distinguishing features of this doctor.

Finally, this GP shared aspects of his own personal life making him relatable and most of all, human. He would tell his patients about his upcoming vacation and even make jokes with his patients.

This GP had the requisite medical knowledge patients come to expect, but provided the intangible human experience that my family and friends were left wanting. The RACGP campaign is correct that 'the good GP never stops learning', not just about medicine, but about themselves and most importantly, their patients.

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SPECIAL REPORT

Dr. Rosalie Cooper of Victoria Medical Women's Society

Biography

Dr. Rosalie Cooper was born in Queenstown, Tasmania and graduated with an MBBS from the University of Melbourne in 1961. She interned at the Royal Melbourne Hospital and is widely travelled, having completed an MSc in Histology in Montreal, trained as a paediatric resident in Toronto and has also trained in London. She became very interested in paediatrics and public health, which inspired her to work for 21 years in Community Child Health and School Health with the Victorian Government. Dr. Cooper has also conducted epidemiological research in the area of Sudden Infant Death Syndrome. Tragically she and her husband lost their second son to SIDS in 1977. While working on perinatal epidemiology at the Centre for Mother's and Children's Health, she was deeply inspired by Dr. Judith Lumley. She then worked as a GP for many years before retiring in 2007. Dr. Cooper has had a long association with Victoria Medical Women's' Society (VMWS) and Australian Federation of Medical Women (AFMW). She was previously President and Secretary of VMWS and National Corresponding Secretary for AFMW, and has now recently returned as Vice President following retirement.

Interview

1. **What does VMWS mean to you and why do you believe it is important to have a medical society dedicated to women?**
   I have been a member of VMWS since I graduated in 1961; there were no student members then. It has been a source of inspiration and friendships. Many of my feminist ideas have been encouraged through this organization.

2. **What do you believe are some of the biggest issues regarding women in medicine or women's health?**
   Women need encouragement and freedom to make their own decisions about their future and lifestyle. Professionally I have been involved with childbirth and parenting areas and the issues for women generally as they pursue careers and family care. Many women need confidence in their birthing and parenting roles especially now that working and a career seems to be expected as well.

3. **You mentioned that you were inspired by Dr Judith Lumley at the Centre for Mother's**

Children's Health. Can you tell us a little bit about why she made such an impression on you?

Judith Lumley is an epidemiologist and scientist who applied the principles of scientific thinking to all areas in which her research and teaching developed. The Centre, now at Latrobe University and called "The Judith Lumley Centre" has brought together a group of people, women and men, who follow the same approach. They focus on mother, child and family issues and consult with other professionals in Melbourne. She was a mentor to me and I spent some time studying neonatal and perinatal death and associated events, using the Perinatal database that Judith supervised in the Victorian Health Department. Judith has retired now.

4. **Have you had to make any sacrifices to get where you are? Were these sacrifices unique to being a woman in medicine?**

   I have made sacrifices but they relate to many issues in my life. I do not regret them now; I am content with the way things have turned out. Some of the issues about being a woman in medicine are, that I experienced a few changes in my personality as I went through the course and trainee years. I was too shy to make good decisions and did not appreciate that I did not have the drive to specialise in medicine or surgery at that time and wasted opportunities to move on. In retrospect I loved my time in public child health, research and general practice, once I experienced those areas.

5. **Do you have any advice for female doctors to balance work, family, friends and finances?**

   This is a hard one to answer. We all have to make our own way. I guess I'd say, make your own decisions" and "don't be influenced by other people's ideas or prejudices. I had to fight against my parents' wishes in order to go into medicine. It's too long, too hard, etc. You will want get married! I never regretted my choice of career although there was an impact on my life. I did marry happily, 13 years after graduation much to my parents' relief!

6. **There was recently an Insight episode regarding bullying of female trainees and medical students and junior doctors by their senior supervisors. Do you think that this is currently a real problem in our profession? What do you think can be done to fix this?**

   I was quite horrified to find out what a serious problem this has become. It has developed into what appears to be an overt situation in surgery with drastic implications for some women trainees. There has always been discrimination in all professional areas, against women and other groups who are "different". Many subtle and not so subtle comments were made to us as students and interns. We generally ignored them or just discussed them among ourselves. Because the proportion of women was only about 10% they did not seem to present such a threat to financial development and status of the men. Female colleagues admired individual women who specialised and did well, however we realized how hard it could be for them. Hopefully the larger percentage of women will provide support and encouragement for the whole group. The training Colleges are the organisation that should look at their approach to fixing these problems.

7. **Last words…**

Medicine is a potentially rewarding profession. Those who have survived the ups and downs of student life and the early years of graduation and training, then find a job that suits them, are lucky if they can also find happiness in family life. There seem to be difficulties for many in adjusting to some of the demands of the profession, others just sail through. In the "old days" many women did not marry and devoted themselves to their career. This has changed enormously now, I think for the better. Another change is that medicine now has many choices for a career. Failure in one area is not a disaster as many other avenues open up. We can even have one or two other things to do while pursuing a main choice; it depends on how flexible one can be. Motherhood and student or intern positions seem to be possible. Training programs need to allow for women to have maternity leave just as women do in employment.

Thank you to Dr. Cooper for taking your time to answer these questions so thoughtfully! I think an interesting point was made about female colleagues being particularly vulnerable targets to bullying in a traditionally male dominated (although this is rapidly changing) profession. I hope everyone can take away some of her advice to help you through your medical career.

Victorian Medical Women's Society

Interview conducted by Sylvia Ye, 3RD Year Geelong Student

VMWS Student Representative

Write for The Pulse

If you have an article or a topic of interest, we would love to hear about it!

Email submissions to publications@medusa.org.au

Students who contribute two or more submissions a year receive a signed certificate from the MeDUSA President.

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