SPRING 2022 | ISSUE 12

# PORT MELBOURNE Medical

PortMelbourne MEDICAL

2 Strain Covid-19 Vaccine

IUD
Intrauterine Device

GP Crisis Summit Update

## Women's Heart Disease

## Updates To Isolation Rules

It is important to us that you understand these terms and conditions which relate to your use of this publication. By accessing and using this publication, you agree to be bound by these terms and conditions and any other terms and conditions, notices and disclaimers displayed elsewhere in this publication relating to your use of this publication.

Whilst appreciable care has been taken in the preparation of this publication, Black Sparrow Group, Black Sparrow Publishing, Vigour Media, Vigour Platform, Vigour Active, Vigour Health & Wellbeing Magazine, its officers, directors, employees, contractors, sponsors, suppliers, editors, authors, subscribing organisations, their servants and agents ("We") provide this for general information purposes only. It is not intended or implied to be a substitute for professional medical advice, diagnosis or treatment.

We cannot warrant the accuracy of this publication beyond the source documents although we do make every attempt to work from authoritative sources. Any representation implied or expressed concerning the efficacy, appropriateness or suitability of any treatment or product is expressly negatived. The material may include the views or recommendations of third parties and does not necessarily reflect the views of Black Sparrow Group, Black Sparrow Publishing, Vigour Media, Vigour Platform, Vigour Health & Wellbeing Magazine, its officers, directors, employees, contractors, sponsors, suppliers, editors, authors, subscribing organisations, their servants and agents.

In view of the possibility of human error or advances in medical knowledge we cannot and do not warrant that the information contained in this publication is in every respect accurate or complete. Accordingly we are not and will not be held responsible or liable for any errors or omissions that may be found in any of the information in this publication.

You are encouraged to consult other sources in order to confirm the information contained in this publication and in the event that medical treatment is required, to take professional, expert advice from a legally qualified and appropriately experienced medical practitioner.

This publication contains links to other websites. We provide these to help you find more information. The linked websites do not necessarily reflect the views of Black Sparrow Group, Black Sparrow Publishing, Vigour Media, Vigour Platform, Vigour Active, Vigour Health & Wellbeing Magazine, its officers, directors, employees, contractors, sponsors, suppliers, editors, authors, subscribing organisations, their servants and agents or our commitment to a particular course of action.

We are careful in selecting the websites we link to, but we are not responsible for and do not necessarily endorse their information. You need to make your own decisions about the accuracy, currency, and reliability of information in linked websites.

Access our full Terms & Conditions

**Port Melbourne Medical Magazine**

**Proudly published by**

Vigour.Media

**For and on behalf of**

PortMelbourne MEDICAL

**Editor in Chief** | Chris Rabba, Vigour.Media

**Port Melbourne Medical**
1 / 405 Bay Street, Port Melbourne,VIC 3207
T: 03 8686 0500
F: 03 8686 0501

**Hours of Operation**
Monday - Thursday 8:00am - 7:00pm
Friday 8:00am - 6:00pm
Saturday 8:30am - 1:30pm
Sunday 9:00am - 1:00pm



Our publication is accessibility friendly. Simply click **Accessibility** on the publication's navigation bar.

An **Accessibility Icon** will appear in the bottom left-hand corner. Click the icon to bring up the Accessibility Panel that will allow you to adjust the publication to meet your specific needs.

You can toggle between the Accessibility view & Standard view by clicking Accessibility on the publication's navigation bar.

# WELCOME

## SPRING 2022

Welcome to the Spring edition of our eMagazine.

We have a lot of news and updates to share with you. Firstly, as we approach mid-Spring, and we are having our third La Niña event in as many years, there is a risk of seasonal / thunderstorm asthma. We encourage you to read our previous blog HERE which discusses why this occurs and what you can do to reduce your risk.

In this issue, we will also provide updates on the new Moderna bivalent vaccine, which generates antibodies against the original Covid-19 virus variant as well as the Omicron variant. We will also provide an update on the dedicated Respiratory Clinic and its expected closure on December 31, 2022 and the ramifications this closure will have on our community beyond that date.

We will introduce our new nursing staff, welcome back Dr Prachi Dadheech, discuss the pros and cons of IUDs and highlight Dr Sarah Lewis' attendance at the RACGP GP Crisis Summit in Canberra.

We are also delighted that Cardiologist Dr Monique Watts has written a comprehensive female heart risk article for this edition, which provides fantastic and interesting updates that we encourage all women to read.

Dr Monique Watts has been instrumental in helping women access cardiac services in Melbourne, having created a specialist women's heart clinic at Victoria Heart, as well as a specialised clinic at the Alfred Hospital – the first of its kind in Victoria.

# Update to **Isolation Rules**

At midnight on the 12th Oct 2022, Victoria eased the mandatory isolation rules for those who test positive to Covid. This is a step towards learning to live with Covid, and treating it as “business as usual”.

Unfortunately, there is contentious evidence for whether this is the best approach when it comes to Covid. Of course, we are all keen to relax our vigilance and enjoy life again.

Although these rules have relaxed, it is still recommended that you continue to isolate if you test positive for Covid (and continue to isolate until your symptoms have cleared).

If you have tested positive for Covid and need help, or have tested positive for Covid but feel well and have other medical needs, please do not enter the clinic without first discussing this with your doctor and letting reception know.

We trust that you will all do the right thing, and continue to utilise telehealth where it is appropriate.

We are well versed with the system now and will be able to advise you on how to best navigate your health if you are Covid positive.

# Thank you!

**Thank you for keeping this clinic a safe place for the elderly patients, the cancer patients, those with a reduced immune system, newborn babies, pregnant women, and all the other people who need to seek their medical care safely.**

# Women's Heart Disease

## a whole other story, it's time you hear it.

Despite heart disease being the number one killer of women globally, most women are unaware of their risk, believing that heart disease is man's disease. Women delay seeking medical attention for heart attack symptoms and are more likely to die in the weeks and months following a heart attack than men.

Given this fact, perhaps it's not surprising to learn that while cardiovascular mortality is clearly falling in men, in women it has not slowed to the same rate and in younger women particularly, cardiovascular mortality is on the rise. Appreciation of these facts has led to a much needed focus on women's heart disease at a scientific, clinical and social level to try to determine the contributing factors to the difference in outcomes between genders.

One such factor is that our understanding of heart disease in women has been based on research undertaken mainly in men. This fails to account for the fact that women's hearts and men's hearts are different. Women have different risk factors for heart disease than men, and often experience very different symptoms. Women also can experience different types of heart attacks to men meaning that the underlying biology and necessary treatment is different.

The traditional risk factors for cardiovascular disease are well appreciated by most and include high blood pressure, high cholesterol, diabetes, smoking and being overweight. These are risk factors in both women and men, although interestingly smoking and diabetes carry a higher risk of heart disease in women than in men. There are also novel or non-traditional 'female specific' risk factors in women, which are non-modifiable. While these are not treatable conditions, they are markers of elevated risk and provide insight into which women should be more closely monitored and have their modifiable risk factors (like blood pressure and cholesterol) more aggressively treated.

These include hormonal factors such as early menopause (menopause before 50, with a dose dependant relationship meaning the earliest menopause is associated with the greatest risk). In fact every woman's risk of heart disease rises at the time of menopause, as changes in lipid profile, body composition and vascular function all occur in response to a hormonal shifts.

In addition to age of menopause, age at menarche (when menstruation first begins) also has an association with cardiovascular risk, with women who undergo early (<10 years of age) or late (>15 years of age) menarche having higher risk of cardiovascular disease. In addition to hormonal factors, pregnancy complications are also a clearly established risk factor for premature cardiovascular disease.

The numerous changes in the cardiovascular system that occur during a normal pregnancy makes pregnancy a stress test for the cardiovascular system. Women who experience pre-eclampsia, gestational diabetes, gestational hypertension, premature delivery or deliver a small for gestational age infant are more likely to develop cardiovascular disease at a younger age.

These risk factors are not taken into consideration when using the traditional cardiovascular risk calculators which may result in an under-estimation of a woman's risk. Other risk factors such as inflammatory conditions including rheumatoid arthritis and lupus also significantly increase an individual's risk of cardiovascular disease. It's important that women discuss their obstetric history, timing of menopause and other medical conditions with their GP when talking about cardiac risk.

As well as having unique risk factors for heart disease, women often present in unique ways. While men classically present with central chest pain that may radiate to the jaw or left shoulder or arm, women are more likely than men to experience other more general symptoms such as overwhelming fatigue, breathlessness, sweating, nausea, dizziness, arm pain/heaviness, chest tightness or pressure, or heartburn-like symptoms. In some cases, women do experience chest pain but have co-existing symptoms (such as dizziness, nausea or fatigue) which can be distracting to both the patient and investigating team making it harder to diagnose a heart attack in a timely fashion.

Delays to diagnosis can mean loss of heart muscle and loss of life. Arming women with knowledge of the atypical symptoms that they may experience when having a heart attack is essential to improving access to timely care and bettering outcomes for women with heart disease.

In addition to different risk factors and symptoms, women may experience different types of heart attacks to men. Our understanding of a “heart attack” has come from research primarily conducted in men, so our understanding of what a “heart attack” looks like is based on a male type heart attack. It transpires that women often have different causes for their heart attacks, making diagnosis and treatment more challenging. A heart attack is caused by an interruption of blood supply to the heart muscle so that the muscle is damaged and, in many cases no longer functions properly.

This is most often caused by cholesterol build up in the arteries (“plaque” or atherosclerosis) that leads to a narrowing in the artery. Sudden blockages can occur when one of the cholesterol deposits/plaques ruptures. This sudden event will usually cause symptoms and investigations such as an ECG (where sticky dots are placed on the chest and a 10 second reading taken that is printed onto a page that like squiggly lines) and blood tests (called a troponin that is a biomarker released from heart muscle that has been damaged) will confirm a diagnosis of a heart attack.

**In addition to different risk factors and symptoms, women may experience different types of heart attacks to men.**

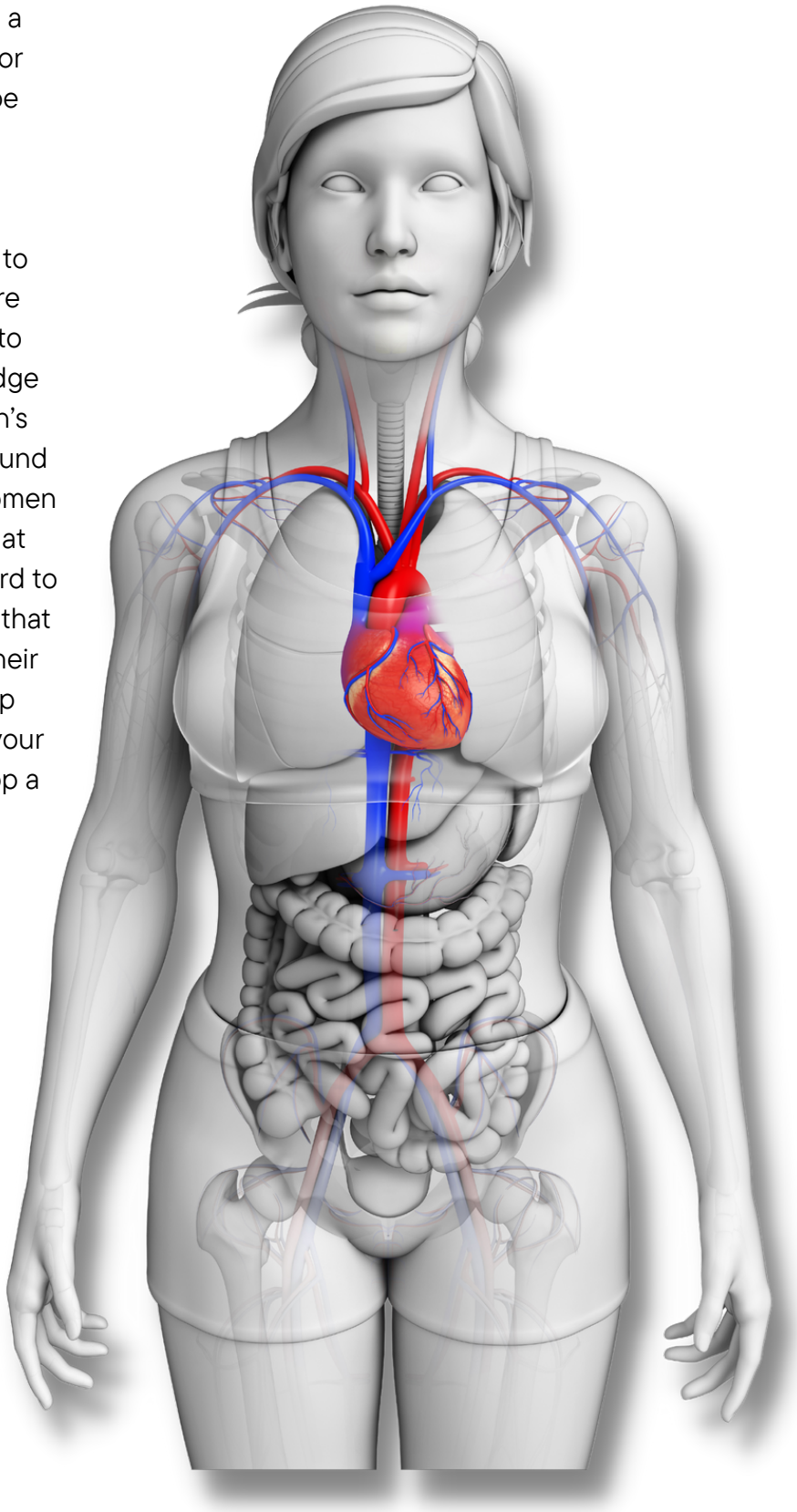
Once this diagnosis has been made, cardiologists will perform a coronary angiography (a dye study of the heart vessels) so that severely narrowed or blocked arteries can be identified and opened up with a stent.
Women are more than twice as likely to have heart attacks without detectable blockages in their arteries at angiography. This is termed a Myocardial Infarction with Nonobstructive Coronary Arteries (MINOCA). This can lead to confusion about the diagnosis and what sort of treatment should be used. Patients who suffer from MINOCA are at elevated risk of poor cardiovascular outcomes (heart attack, stroke, heart failure) and repeated cardiac investigations.

There are many different causes of MINOCA, some of which require very different types of therapy than those implemented in classical atherosclerotic coronary artery disease. Some of the more common causes of MINOCA are coronary artery vasospasm (where the heart arteries spasm down to temporarily restrict blood supply) or microvascular dysfunction (where there's a problem with the small vessels that aren't imaged by a conventional angiogram), takotsubo cardiomyopathy (a transient malfunctioning of the heart muscle due to sudden stress) or spontaneous coronary artery dissection (where the heart artery wall tears or a bleed occurs within the artery wall).

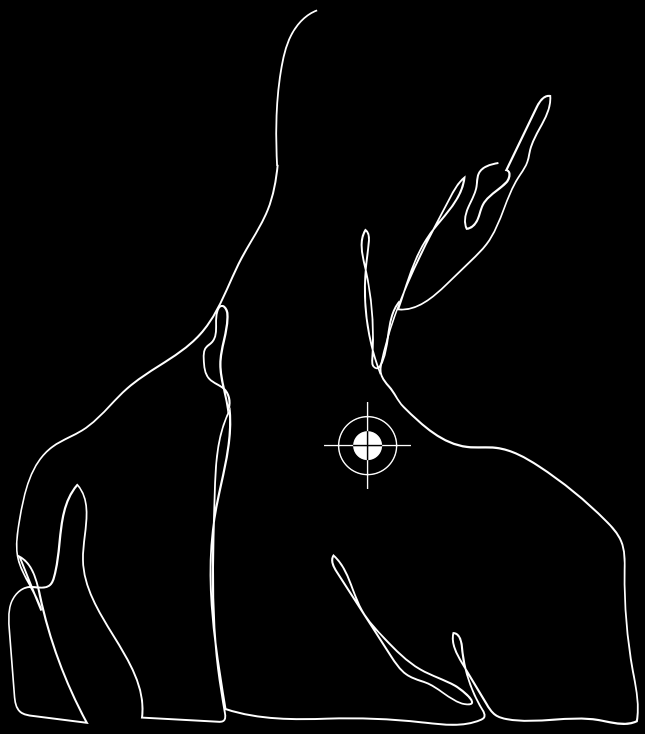
A diagnosis of MINOCA should inspire a search for the underlying mechanism or cause so that correct treatment may be implemented and further events prevented.

The era of Women's Cardiology is late to the arena but finally here. There is more research than ever being undertaken to better our understanding and knowledge of heart disease in women and Women's Heart Clinics are being developed around the world to provide expert care to women experiencing heart disease and those at risk of heart disease. We're working hard to increase awareness and education so that women everywhere can understand their risk, know the symptoms, and seek help early should they need it. Speak with your GP about your cardiac risk and develop a plan to minimise it.

*References:*
*1. The Lancet. VOLUME 396, ISSUE 10244, P72-73,*
*2. Tex Heart Inst J. 2011; 38(2): 148–150.*
*3. The Lancet. VOLUME 393, ISSUE 10175, P959, MARCH 09, 2019*
*4. Am Heart Assoc. 2019 Jun 18; 8(12): e012406.*
*5. Clin Cardiol. 2018 Feb; 41(2): 185–193.*



**Dr Monique Watts**
*Cardiologist – MBBS BMedSci, FRACP*
*Women's Heart Clinic at The Alfred, Victoria Heart*



## Port Melbourne
# Skin Cancer Clinic

The physical premise of the Respiratory Clinic was initially designed as a Skin Cancer Clinic. We are excited to clean, repaint and refurbish this purpose-built space and offer a dedicated Skin Cancer Clinic, where we will offer skin checks, mole mapping, as well as medical and surgical treatments for various skin cancers and pre-cancers, in line with the most up to date evidence and guidelines.

**We look forward to updating you further closer to the time. In the meantime, Dr Jeet Garud continues to offer skin checks and mole removals through his consulting services at PMM.**

UPDATE

# Port Melbourne
# Respiratory Clinic

The Federal Department of Health and Aged Care recently extended our contract to operate the Respiratory Clinic until December 31, 2022. At this stage, the Government has indicated that they do not intend to renew the program beyond this date. In fact, some clinics across the country were not offered an extension beyond September 30 and have now closed.

The expected closure will have serious impacts for patients, who have relied on the clinics for the assessment and treatment of Covid-19 and is done against the backdrop of a predicted Covid-19 wave in November in Melbourne. We continue to seek a detailed plan on how we manage Covid-19 and respiratory infections in our region post our closure date from all layers of Government, and are still awaiting formal instruction. As we make further plans for how Covid-19 assessments and respiratory infections will be managed from 2023, we will update you via email and our website.

We appreciate that the free service has been valuable for many people and we are awaiting Government recommendation of where they would like us to direct people who will be unable to pay for this service (which will be necessary as it will no longer be funded through this clinic after December 31).

We anticipate that those who are unable to afford private fees will need to find a Victorian Government GP Respiratory Clinic, or will need to attend the Alfred Hospital or Royal Children's Hospital. The Victorian Government Respiratory Clinics will remain open at this stage, with the closest to Port Melbourne being located in West Melbourne, North Melbourne and Murrumbeena.

Currently, we continue to operate PMRC 7 days per week with reduced hours. We acknowledge that the local and wider community have relied upon PMRC over the past 2.5 years, allowing access to doctors at a time when this access was restricted for many people across the country.

Please be aware that all services that are available with no payment will cease at the end of the year due to this funding being removed. This includes general respiratory examinations for adults and children with coughs/colds/tonsillitis, etc, Covid-19 positive telehealth and antiviral prescribing, and Covid-19 positive face-to-face assessments.

Whilst the business community and Government understandably want a business-as-usual approach, this needs to be balanced with the current medical advice.

Unfortunately, removal of masks in most settings, abolishment of mandatory isolation for Covid-19 infection, open borders and a population that is not up to date with booster doses is a high-risk combination for virus mutations. In addition, mounting evidence points to the fact that people have more health risks with each infection of Covid-19.

Once the various Governments provide us with the requested information, we will evaluate if a hybrid clinic or partial service can be safely delivered. However, in line with other services, there will be the usual fees for consultations, and there will likely be an additional PPE charge as well. We will communicate the processes and fees once these plans are finalised. We appreciate the fine balance between providing accessible and affordable care, ensuring we are keeping the business viable, and ensuring the safety of those who attend the clinic who are more vulnerable to the effects of Covid-19.

We would like to thank our patients who attended PMRC for working with us during the pandemic. It has been one of the scariest times in our lives, and we took great pride in being able to help provide an excellent health solution for our community.

As Clinical Director, I also want to acknowledge and thank the 21 doctors, nurses and receptionists who worked there and delivered some 63,000+ consultations – an amazing effort.

We must also acknowledge and thank our management and nursing team who kept the place running on top of their usual work, and PMM's reception team who took thousands of calls and guided many patients through a confusing time. It's worth remembering this was done in conjunction with the vaccine roll out and administering some 32,000 vaccines.

I know the GPRC program made a material impact in our community, reduced spread and saved the hospitals & emergency departments from being overrun and potentially collapsing. In addition, it enabled early medical intervention, saved many lives, provided important education and has clearly and remarkably improved patient health outcomes.

**Dr Sarah Lewis**
***PMM & PMRC Clinical Director***

**21**
**Drs, Nurses & Admin Staff**

**63K**
**Consultations**

**32K**
**Vaccines Administered**

# Dr Prachi Dadheech
## is back at PMM

**We are very excited that Dr Prachi Dadheech has resumed consulting from Port Melbourne Medical.**

Dr Prachi brings a wealth of expertise and experience, and can offer female patients the option of IUD insertion.

# New Nurses

We welcome new nurses Hawa and Rebecca. Hawa has a special interest in both Aged Care and General Practice nursing. Rebecca has extensive experience in skin cancer and will be working closely with Dr Jeet. They both have brought a wealth of experience, and we look forward to you meeting them.

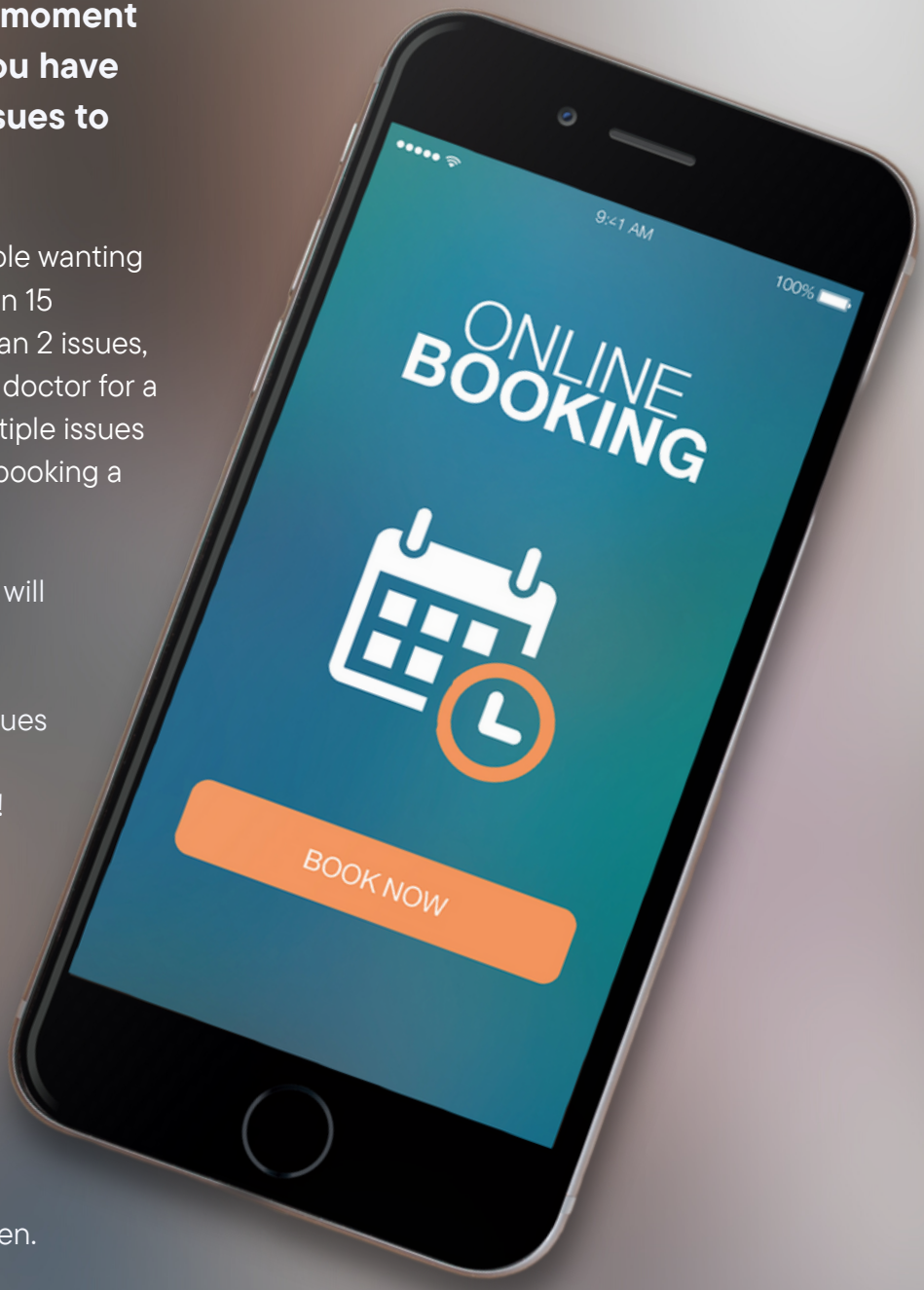
# Bookings

**When booking your appointments at Port Melbourne Medical, please take a moment to consider whether you have multiple or complex issues to discuss.**

We do sometimes have people wanting to discuss 7 different issues in 15 minutes. If you have more than 2 issues, or if you haven't been to the doctor for a long time and may need multiple issues addressed, please consider booking a longer appointment.

Mental health appointments will also generally need a longer appointment. This helps the doctor both address your issues on the day AND run on-time, which everyone appreciates!

Please remember you don't need to call reception to tell us you have arrived. We assume that you are here and the doctor or nurse will call you on your phone or come to the front and collect you when you are ready to be seen.



NEW NURSE

# HAWA

profile

## EDUCATION

Bachelor of Nursing (La Trobe University)

## NURSING CAREER

Diverse nursing experience over the last 8 years; including working at the Royal Melbourne, Western and Austin Hospitals.

## SPECIAL INTERESTS

Aged Care and General Practice Nursing.

## SPARE TIME

Traveling, Outdoor Activities and Swimming.

NEW NURSE

# REBECCA

profile

## EDUCATION

Bachelor Nursing – Australian Catholic University; Nurse Immuniser – La Trobe University, currently studying Dermoscopy.

## NURSING CAREER

Various roles over the past 15 years throughout Melbourne in Aged Care, Acute, General Practice and in Community Health. The roles included General Practice nursing for 11 years and Nurse immuniser for 10 years. I also have a keen interest in Skin Cancer prevention, detection and treatment - therefore I have recently commenced Certificate III in Dermoscopy and will work through to complete the Diploma.

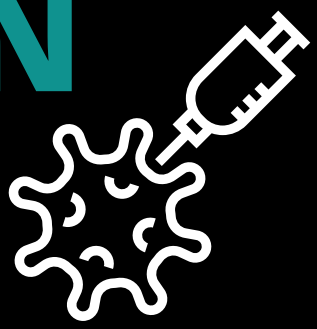
## SPECIAL INTERESTS

General Practice Nursing, Immunisations, AOD Support, Mental Health Support, Case Management, Aged Care, Chronic Disease Management and health promotion.

## SPARE TIME

I enjoy spending time with family and friends, all things food related, camping, gardening, long walks with the dog and newly found interest in hiking.

# 2 STRAIN COVID-19 VACCINE



## MODERNA BIVALENT (2 STRAINS) VACCINE

On August 29th 2022, the TGA granted provisional registration for the Moderna Spikevax Bivalent (Original & Omicron BA.1) vaccine for use as a booster in people aged 18 years and older. It is unclear what the stock availability will be like, with mixed reports about how many doses will be delivered to Australia. We are expecting to receive some stock in the next 1-2 weeks and will advise once this is available for booking.

All the vaccines that have been available to date were designed to provide protection against the original Covid virus variant. We have found that these original vaccines have also offered some protection against the various Omicron strains.

The new Moderna bivalent vaccine has been shown to offer a higher degree of immune response against the various Omicron variants compared to the original Moderna vaccine.

The published data reports that the new Moderna bivalent vaccine generates a modestly higher level of antibody response against multiple Omicron subvariants (approx. 1.6-1.9 times) including BA.1 and BA.4/BA.5, and a similar antibody response against the original virus compared to the original Moderna vaccine. How this translates to real life (reduction in infection, reduction in severity and protection against future variants) is uncertain at this stage but will be monitored both in Australia and overseas.

It is anticipated that the duration of protection will be similar to the original Moderna vaccine. The safety profile of the bivalent vaccine as a booster dose in adults appears similar to the original vaccine.

**Booking eligibility:**

- You must be over 18; AND
- This must be a booster dose; AND
- If you have had a Covid infection, you must be 3 months since this infection; AND
- You must be due for your booster dose*

**Booster doses (e.g., vaccine dose 3 or 4 for those who did require additional doses of the primary course due to immunocompromise) must be at least 3 months after your last vaccine. This cannot be given to people who would like an additional vaccine, but are not eligible. ATAGI have not yet authorised a 3rd booster dose and so if you have had 2 booster doses already, we cannot offer another at this stage.*

# IUD

## Intrauterine Device

*by Dr Prachi Dadheech*

An Intrauterine Device (or IUD) is a long-acting reversible contraceptive, or LARC for short. LARCs are a popular option for many women, as they don't have to remember a pill every day. There are several different types of LARCs, being Implanon, Injectable and IUDs. This article is an overview of IUDs.

In Australia, there are 2 types of IUDs available for use: hormonal (sold as Mirena and Kyleena) and non-hormonal (Copper IUD, or Cu-IUD).

The IUD is a small plastic and/or metal device inserted into the womb, or uterus, to prevent a pregnancy.

## Hormonal IUD

These are a T-shaped device made of plastic inserted into the womb. The hormonal IUD works by slowly releasing the hormone progestogen into the uterus. Progestogen is the synthetic version of the hormone made by the ovaries, progesterone. Mirena and Kyleena have the same hormone, but Kyleena is a smaller and lower dose option which may be more appropriate for some women.

## Copper IUD

These are non-hormonal devices, made of plastic and copper. The copper is released slowly into the uterus.

## How effective are they and how long do they last?

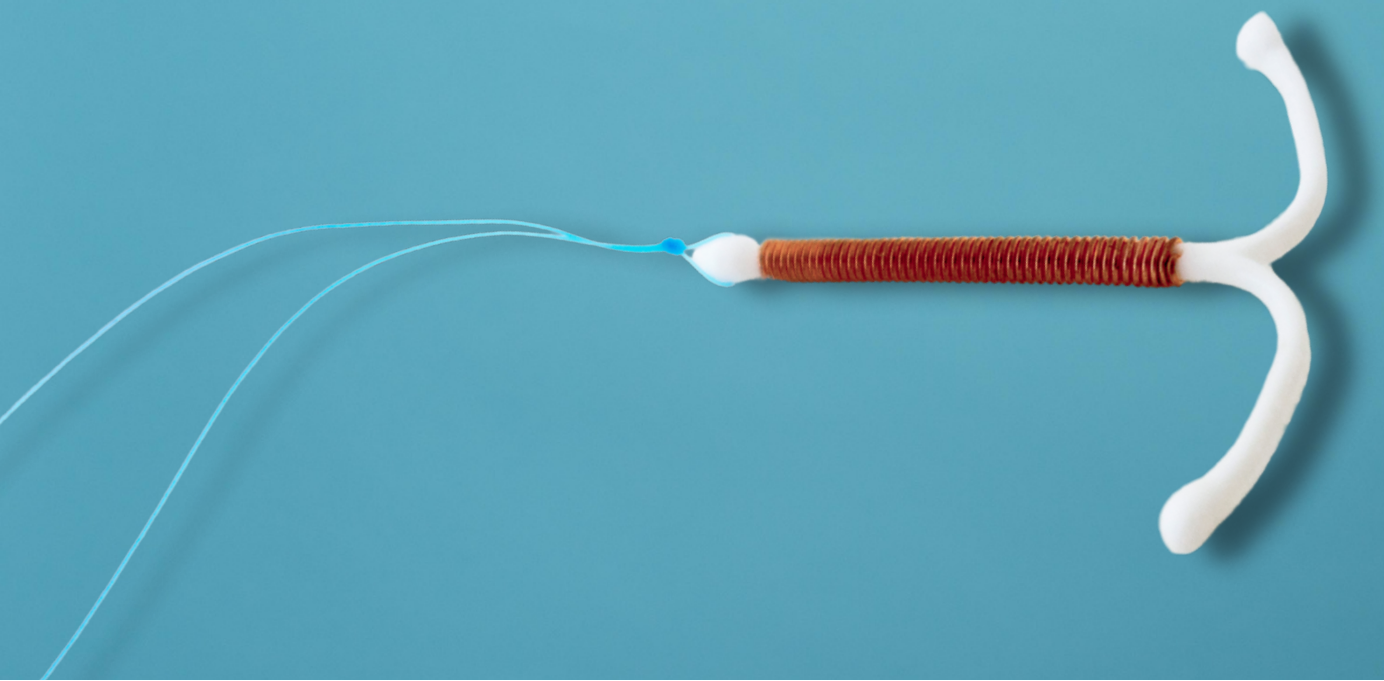
IUDs are over 99% effective at preventing a pregnancy, only 1 in 100 women with an IUD will fall pregnant each year. In comparison, the combined oral contraceptive pill is also 99% effective with perfect use, but is closer to 93% with typical use. The hormonal IUD can last for up to 5 years as a contraceptive and the Copper IUD lasts for up to 5 or 10 years.

## How do they work?

The IUDs affect the way sperm enter and move in the uterus, stopping them reaching and fertilising an egg. IUDs also thin the lining of the womb, so if an egg has been fertilised it will be difficult to stick to the lining of the uterus to start a pregnancy. The hormonal IUD may also prevent ovulation (the release of the egg from the ovaries) which reduces the chance of a pregnancy further.

## Advantages

- IUDs are long acting, meaning they last for 5 – 10 years depending on the type of IUD used
- They are reversible, so once removed your fertility should quickly return to what is normal for you.
- They can be used whilst breast feeding.
- They very rarely interact with other medications.
- It is a great alternative contraception if you are having difficulty with other methods e.g. remembering to take the pill.
- The Copper IUD doesn't contain any hormones, which makes it a good option for women needing contraception but reluctant to take hormones for various reasons.
- The Mirena can be used to reduce heavy and/or painful periods. Many women report very little or no periods after a few months of insertion.
- Both IUDs are generally safe for women who cannot take oestrogen containing contraceptives, due to underlying health conditions or other medication.
- Although they can be a little more expensive upfront, they will often be cheaper in the longer term.



## Disadvantages

- Both types will need to be inserted by a trained clinician.
- Most women will notice a change in their bleeding pattern (period) especially the initial 3-6months after insertion.
- There may be cramping pain during insertion which usually settles after a few days.
- The IUD does not offer protection against sexually transmitted infections.
- The IUD may fall out. This is more common within the first few months of insertion.
- There is a small chance of making a small hole in the uterus wall during insertion, this means the IUD may move out of place and you will need keyhole surgery to have the Mirena removed.
- There is a small chance of pregnancy with an IUD in place. Should you fall pregnant, there is a chance of an ectopic pregnancy (where the pregnancy sits in the fallopian tubes, not in the uterus).

## How is an IUD inserted

IUD is inserted in the uterus with a local anaesthetic spray. The procedure itself takes about 15 minutes but you will be in the clinic for an hour or so.

## I am interested in an IUD - what do I do next?

A pre-IUD insertion appointment with Dr Prachi will be required. During this consultation you will be asked questions with regards to your medical, gynaecological and sexual health in order for the Doctor to assess your suitability for the IUD as well as an opportunity for you to discuss any concerns or questions you may have.

Following this you will be advised when to make the appointment for the insertion of the IUD.

This is not a commitment to having an IUD. During this discussion it may become clear that you would be better suited to a different contraceptive option, which can be discussed/prescribed instead.

## What are the charges?

If you have a Medicare card, the Mirena and Kyleena are the cost of a PBS (Pharmaceutical Benefits Scheme – meaning the Government subsides the cost of certain medication to make it more accessible) script, which is now around the $42 mark. If you do not have Medicare subsiding the cost, they are around the $220+ and $170+ mark respectively, but will vary pharmacy to pharmacy. Some overseas health insurances may match the PBS subsidy.

Copper IUDs cost around $80-100. Some private health insurance companies may subsidise the costs of non-PBS medication.

**IUD insertion prices are as follows:**

- Initial long consultation for discussion/planning and education is $145 with a Medicare rebate of $76.95 (out of pocket $68.05)
- Insertion appointment is $262.55 with a Medicare rebate of $80.59 (out of pocket $181.96)

*(This includes a total of $262.65, with a rebate of $8.65 for the pregnancy test which is routinely performed, and a rebate of $72.05 for the IUD insertion).*

Considering the IUD can last from 5-10 years, this becomes a very cost-effective option quite quickly.

This may be cheaper if you have reached your Medicare Safety Net.

## What happens after the insertion of an IUD?

On the day of the procedure the Nurse will discuss with you the post-insertion safety leaflet.

At 6 weeks after insertion of the IUD you will be asked to see your GP again for a quick examination to check the IUD is in place.

IUDs can be removed at any stage during a standard consultation. If you need to discuss another form of contraception as well, a longer appointment type should be selected.

**Dr Prachi Dadheech is qualified to insert Mirena and Kyleena IUDs**

ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS (RACGP)

# GP CRISIS

## SUMMIT - UPDATE

On Wednesday 5th of October, RACGP leadership and key healthcare stakeholders including patient representative groups as well as other industry bodies such as Australian Medical Association (AMA), AGPA (Australian GP Alliance), Primary Health Networks (PHNs), and many more gathered at Old Parliament House in Canberra to discuss issues and solutions to the current GP Crisis. Port Melbourne Medical Clinical Director Dr Sarah Lewis was privileged to be invited to attend as one of the 120 delegates for the full day event.

With significant effective reductions in funding from successive Governments and worsening conditions for GPs, less doctors are choosing to enter GP training, and more doctors are reducing their hours, leaving the profession entirely to work in other areas of health, or retiring early. It is estimated there will be a ~30% gap (a shortage of 10,000 GPs) by 2032.

The pandemic has revealed many cracks in the system, but it was not the pandemic alone that caused them.

Access to good quality GP care is vital. We know investment in primary care reduces hospital admissions and disease burden.  The patient rebates for GP consultations were frozen for many years, and then the annual increases have been significantly lower than inflation. This, coupled with the fact that the costs of running a clinic have increased at a rate much higher than CPI, means many practices who previously operated on a bulk bill model can no longer bulk bill vulnerable patients, and many such clinics have closed due to lack of viability.

Even clinics that do not routinely bulk bill have had to increase fees due to rising costs. We do not want health care to be inaccessible to the Australian population.

Issues discussed included funding models, workforce and data governance. It was an inspiring day, full of passionate people. Federal Health and Aged Care Minister Mark Butler has stated that his top priority is addressing the “terrifying” looming shortage of general practitioners.

Dr Sarah Lewis will update our patients as much needed and urgent reforms are announced.