GP LINK Lunches | Dr Andrew Knight

Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.

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Ken McCroary - Sydney Southwest GP Link continues efforts to break down the silos between the community practicing general practitioners in South Western Sydney and our medical colleagues working throughout the local health districts' public hospital system.

We currently interact with like-minded individuals and one such individual is Dr Andrew Knight.

Dr Andrew Knight has been a general practitioner for 35 years. He is a staff specialist at the South Western Sydney Primary and Integrated Care Unit, a conjoint Senior lecturer at the University of NSW and was chair of National Prescribing Services Medicine Wise - The National Prescribing Service.

Andrew was a director of training in the Australian General Practice Training Program and has been involved in general practice divisions and Medicare Local. He was the chair of the Nepean Blue Mountains Primary Health Network until 2019. He is particularly interested in general practice quality improvement through his role with the Australian Primary Care Collaborative Program.

With the sudden and disappointing demise of NPS Medicine Wise, I thought now would be a great time to speak to Andrew about his role with this service but also his other interests in GP training and quality improvements.

Andrew, could you give us a bit of a reminder about NPS and Medicine Wise, the journey and the organisation. What are your thoughts about some of the significant or major achievements over the years and then, of course, your role in the service please?

Andrew Knight - Sure, absolutely Ken. Look I don't know if you remember but I recall pretty clearly in the late '90s when suddenly we started getting visits from people, who were not drug reps, to talk to us about quality use of medicines - and I really liked it. I stopped seeing drug reps at the time because I was really interested in EBM; I appreciated getting the evidence presented to me. As a GP I really appreciated this idea. And it came from what was a brilliant idea, and that was that academic detailing what we knew worked. You know, getting someone unbiased to actually go and sit with a GP and talk with them about prescribing. This really worked in terms of changing behaviour and there was good evidence of that. But also, we know good prescribing usually saves money. Usually, the medications used may be less expensive, more effective ... whatever. So, there was a really good case for doing it because it actually saved money on. PBS. This was a brilliant idea, I thought, and I watched it develop with NPS over the years - they both improved the quality of prescribing but also saved money for the system. This obviously assisted a lot of other things. When an opportunity came for me to join the board, I was really pleased. I was on the board for 12 years and I saw an effective company - a high quality company - that produced great materials for GPs. Over the years, we added savings every year, as well as

improving (we know they improved and we also improved to prescribe), to the chant of $1 billion. Over 24 years the company saved more than $1 billion dollars in terms of PBS and NBS expenditure. It paid for itself while doing good. To me, that is a great idea. And, as it went along, it added a few other strengths to the bow as well. To measure the impact, it developed a measuring program called Medicine Insight - which many of your readers may have participated in. It was high-quality data extracting. It was like PENCAT, but on steroids, and it validated research quality data from a sample of practices. Something like almost 10% of practices across the country participated to provide this research quality data, which had been validated. So, with good-measure changes in GP behaviour, we could measure the impact of various interventions. All sorts of people were interested in that data, and that data has become very highly prized by many different researchers. And then, of course, there is the website as well where this information was made available to the public. It became a very highly prized consumer resource as well. So that is really what the company did – it grew from very small beginnings to something like an individual with a phone, to the point where it was turning over something like $ 30 million a year to do all this work. That is the company and that is what it did. I think I was really enthusiastic about it as a GP and really pleased to end up being chair of the organisation. Frankly, I was very disappointed part of the funding was pulled for something I thought was so useful.

Ken McCroary - I must clarify EBM is evidence-based medicine and I was thinking, yes, what an achievement to be a revenue-neutral benefit society. But from your figures - 24 years at $30 million - you finished in the black by more than a quarter of a billion dollars ... so it is a revenue-positive thing. And that is what I was going to talk about next: the Federal Government's recent decisions leading to the service's demise due to the cessation of funding and how the program is now being redesigned as part of quality medicines programs with other entities. Can you go into that a bit for us, please?

Andrew Knight - The justification is that the environment has changed, and I think there is truth in that. When MBS began there were no other organisations. There was no Australian Community Office at that stage of quality health care. There now are a number of other organisations operating in that space and looking at the quality use of medicines. PHN, of course, has come to the fore in terms of its support of quality in general practice, so it is a very different environment. The argument was: is it still the right mode? To be honest, Ken, I don't think it was a policy-driven decision. I think it was political and, frankly, I don't really understand. Government programs often have a timeframe, and they reach their use by date for reasons often not to do with policy but politics. We did our level best to argue that having this established organisation, an internationally acknowledged valuable organisation, why wouldn't you develop and use it and make changes if you need to - rather than pull the whole plug. The intention is many of the functions will continue. The new government has reviewed the decision and decided to uphold it. I respect the right of governments to make decisions; they have to make the final decision. I just want to be reassured it was done on good policy grounds. When the review was published that justified the decision, we certainly had concerns with it. The content didn't seem to justify the decision. I also acknowledge we were biased because we had great enthusiasm for the organisation. The Medicine Inside function I mentioned was identified as really valuable, and there is a list of express content that will continue. I encourage any practices involved in Medicine Inside to continue, and hopefully the function will continue to make its contribution. There is an intent to continue the practitioner education programs or the intervention, and again we hope the expertise will continue. I encourage everyone to watch and hold the various organisations to account. A lot of the functions have merged. The Australian Commission of Safety and Quality Health Care traditionally has been much more of a standards organisation. It's been a very important, effective and good organisation for the health system. But it hasn't been an implementation organisation until now, so I hope they will be able to implement well. We will see.

Ken McCroary - Yes, and I think your feelings of bias are well-placed because I think you did offer a really terrific service. Before we started talking today, I had just finished a multi-disciplinary meeting with our team at work. One of the new fellow doctors asked, when I told her who I would be talking to if the data would still be on the NPS website because she loved the handouts and particularly the antidepressant changeover charts and all that sort of stuff. She had been quite distressed about the funding news. What can I tell them in terms of the website and the resources still being available? Or are we starting from scratch again?

Andrew Knight - Our understanding is all the IT is transferring to the Commission and it is their responsibility to make sure these things are available. More than that, we have paid to have an ongoing website presence. We have thought very carefully about legacy and made sure the website continues. Of course, we won't be around to maintain it so it will become increasingly less relevant as the years go by. But there is a commitment from government that the resource is produced and will continue to be available. So, yes, in the short-term it will continue. We thought very carefully about what we wanted to make sure happened with this and one of the things we identified as a priority was legacy. As part of the wind-up of the company, we put aside money to pay for the website to remain online for a period of, I think, three years and so it will continue to be available as of now.

Ken McCroary - That is reassuring news and we appreciate the Board's foresight in doing that. It is excellent. Now you yourself are very interesting. NPS is only one of your very many roles. You also have a staff specialist position, and I am wondering about some insight, for people reading today, as to what life is like as a GP working as a staff specialist?

Andrew Knight - Well, I think it is really interesting. I hope this will be something that can grow because clearly GPs have skills, knowledge, connections and understanding of what local health districts right across the country need. I think this could work well in the future, that we as specialists could be employed in local health districts to provide clinical services and to also have input at committee and policy levels. My specific position came about because I joined an academic unit – I'd had an academic interest for a long time and Professor GP Unit was a famous academic unit. Many would have heard of it. It was established in the '80s, and it has had an impact on many aspects of general practice. Many chronic disease item numbers came out of research by the Professor GP Unit. It was quite influential in the establishment of Pavilions as well. Fairfield Provisional was one of the first established in the country. I joined as a staff specialist half-time. It paid a salary, which was unusual that a GP would be paid a salary. I had been in mainstream general practice for about 30 years when I did that, so I really understood the MBS issue - the need to see lots of patients. To be released from that was a huge change, which I have appreciated. It's been a huge positive for me to be set free to do other things and have a different way of working and living. I hope and expect that increasingly GPs will have opportunities to do this sort of work. The unit is no longer called the GP Unit. We are now the Primary Integrated Care Unit, and our clinical work has refocused on primary care to people with severe chronic mental illness. It is interesting ... I think we all know the MBS system is not well set up for certain people with severe chronic mental illness who have trouble keeping appointments. Those long appointment, in relation to MBS rebates, do not renumerate clinicians to do the sort of work people with severe chronic mental illness need. Yet those people die 10 to 20 years younger than the average population because of GP-sensitive conditions like diabetes, COPD, cardiovascular disease and other preventable conditions. This is where I am and what I'm doing now in terms of my clinical work. There is also some academic and teaching work involved in that.

Ken McCroary - Yes, I have to say the MBS systems has brought all sorts of chronic health renumeration really, not just mental health, but that is another day. I spent quite a lot of time at the Fairfield GP Unit doing my training through the RACGP when they were last running training back in the '90s, I believe. You were a registrar there, were you?

Andrew Knight - Yes, I was a registrar who went to Fairfield. I wasn't actually doing my time at Fairfield, but we spent a lot of time at the hospital there with Mark Harris and the rest of the team; John Crimmins and those fellows teaching us many, many fantastic lessons for the rest of our career, for sure. I thought it was a great service.

Ken McCroary - So, let's close it down. You also talk a lot about your interest in quality improvement and your involvement with the Australian Primary Care Collaborative, so I was just wondering about the programs the collaborative runs and your roles and interests in QI. Can you expand on that for me?

Andrew Knight - Part of my interest when I was a registrar, and probably a bit before you, I was fortunate enough to go to a workshop with David Sutton, who was considered the father of EBM. I was a bit converted.

The idea you would only recommend things to people for which there was good evidence really appealed to me, so we don't do things which are harmful. I am also aware we do things to people for which evidence might not be strong, but it is still the best thing we can think of - and that is fine. I was really interested in EBM, which led me to doing a master's degree in clinical epidemiology. But there was an experience in the early 2000s of realising even we as clinicians might know a bit about the evidence. The therapeutic guidelines or whatever, there wasn't enough really to make change. Clinicians don't necessarily change. I didn't necessarily change just because of knowing. A lot of it is a systems problem - how do you get the system working in the hospital or specifically in general practice, which is what interested me to support clinicians to make it easy to do the best thing. And what about the people with diabetes that we don't see.? I am fine to look after the people we do see well, or we think we do. Or do we? Do we measure it? But what about the people we don't see? Who is on our books? Who should be coming? Who isn't coming? And how do you identify and manage a population? There is the whole idea of systems thinking and applying it to what we do. When I started in general practice it was all about the person in front of me. I appreciate you must serve the person in front of you really well. But I think we are shifting to the idea that we as practices serve the population, and I know we serve that population best. Economic collaboratives were started in 2004 and received big funding through the Liberal Government of the day to do this project called Collaboratives. Their short-term big leap was in QI. At the time we got groups of 100 practices together, we took them away to free workshops, we trained them in quality improvement methodology, and we provided support through divisions to actually learn and practice the quality improvement methodology. We measured and extracted data for the first time in general practice using PENCAT and other tools which were developed for the collaboratives, and then we worked at practices, people got competitive, they compared notes with each other, they invented new systems, and we were able to demonstrate change. Remarkable change in that cohort of 100 practices will start with 22% of their patients at a target for HBA1C, like less than or equal to seven, and they would end up with maybe 38-40%. They mainly had an almost 50% improvement in the number of people who had measured to be a target. And that translated at a population level as health-changing, which is potentially huge. I was really inspired and interested in that. When I was involved with the Nepean Blue Mountains PHN and the Medicare Local PHN, I was able to get quality improvement happening there. Keith McDonald has been a great advocate for QI in South Western Sydney … there is a great QI program happening across South Western Sydney focused on learning how to improve things. It is not intuitive for us humans to learn how to improve things. We are all full of good ideas. Always in any practice I have ever worked in you know you sit around at morning tea or at lunch, and if you see people you think of ways to do things better. But is it better? Do we measure it? And how do you implement it? Do you make major changes, or do you make littler changes and measure? And all these sorts of ideas have come from industry. They know how to do it in Toyota. Mazda also do it well. But we don't necessarily learn when we go through uni how to manage your practice and improve the systems. This QI knowledge was really training GPs, practice managers and practice nurses in those industrial methods if you like, on how they could improve the quality of the service we provided. A lot of practices got really inspired by that, and there is a lot of high-quality practices across the country that participated. They ran from 2004 to 2014, and I think they were influential in changing the culture of general practice across the country and teaching people about QI. I analysed that work and I have published a bit of it, which has been a really good experience as well. I wanted to make sure the work that was done was on the record, so people can go back and read that. It is easy to search for my name; you will find lots of articles on the Collaborative that describe the story of what happened in Australia - which is really a remarkable story. It is one of the biggest general practice quality improvement interventions, I think, in the world.

Ken McCroary - As a systems fan boy myself, I think you should be highly commended for that work. I thought it was terrific. The more we can integrate the more we can collaborate, and that leads to systems that have actual evidence behind them in terms of our patient management with KPI outcomes for our patient wellbeing and achievements. I think it is going to be better for everyone, isn't it?

Andrew Knight - That is right, and the other thing that I did was this systematic review, Ken, which looked at the use of collaboratives in general practice. What are they good for? What do people who have done them say they are good for? And yes, people love the fact they are providing better quality care, but they also say they can build capacity within practices and providers because of the connections that happen between clinicians. I

see a lot of GPs and I have heard you say, and others say, they can feel pretty discouraged by the workload from the pandemic and funding constraints and so on. How are we going to reinvigorate the profession? How are we going to provide the champions of tomorrow? I think these sorts of QI initiatives really can help to enthuse and inspire people. They are one way we can help if we were able to do some more things like this. I think it has real potential, improving practices and providers.; improving the system things like measurement, implementing guidelines that would improve the system, and you could also teach QI skills to practices so you can actually employ QI as part of practice. After I have finished publishing all these things, I am going to write to various people and encourage them to do something similar. There is not much money around I don't think, but why wouldn't you invest in general practice? It is by far the most effective and efficient way to improve the health system if you just put a bit of money into improving the experience of the clinicians and the practices. Anyway, that is my idea.

Ken McCroary - I would support and co-sign your letters, for sure. I think there is plenty of money around; it just needs to be used more efficiently and more appropriately. It is something we need to be advocating for, there is no doubt about that. You mentioned the divisions and the Medicare Locals and it's a good time to segway into that. You and I liaise a lot at various PHN committees, etc. How do you see the evolution from GP divisions to Medicare Locals and finally to the current PHNs. What are the implications for GPs along this journey and where do they go from here?

Andrew Knight - I did most of my practice in the Blue Mountains and I was part of the Blue Mountains division and got on the board there. It was a fantastic division. I see a lot of similarities with what happened in South Western Sydney to some fantastic divisions there, and the transition to Medicare Locals was painful. There was a bit of negativity about general practice in the transition to Medicare Locals. You know you weren't allowed to have too many GPs on the board and so on, and I think some of the Medicare Locals were perhaps at bit constrained in their ability and perhaps even in their intent in supporting general practice. I think the transition to PHNs corrected that to an extent. But I must face the fact I am a GP and GPs do most of the primary healthcare work in the country. We know it is the most influential sector in terms of quality. I think PHNs need to maintain their absolute capacity and commitment to supporting, improving and caring for general practice. We must not lose sight of that. In the Nepean Blue Mountains we maintained a presence on the board, and we have specific General Practice Clinical Councils to ensure we have heard the voices of Blue Mountains GPs. I think the move to PHN has been really important. You need to have those regional organisations. I think people still remember they took our money and gave it to the Medicare Local, but we have to grow up and get over that. We need these organisations. I think the idea practices can work in isolation is part of the bygone era. We need to be part of region, part of the population; we need to support work. We need the infrastructure to collect data and feed it back. We need the infrastructure to improve practices and take us all on the journey. But I think PHNs also need to recognise that - and they do - but I think we need to keep in mind it is not just about getting money which is then used for commissioning for mental health services and so on, even though that is really important. To me the key role is general practice, and the key function of PHN is primary care, by which I mean general practice - general practice in the broadest, most multi-disciplinary conception team-based care. There is time to think and improve, bringing allied health in as part of it the local team (even if they are not under the roof of general practice), absolutely improving allied health care, and absolutely improving integration with the primary care functions of the LHDs. PHNs need to do the whole package - so I am all for them. I have been the chair of Nepean Blue Mountains and I enjoy being involved with South West Sydney PHN. I am all for them, but I think they need to absolutely keep their eyes on the ball in terms of the goal – which is to enable local clinicians to do their job. That is what they are about. It is an enabling organisation in the sense they are not an end to themselves; they are there to help the clinicians do the work and they must keep their eye on that ball.

Ken McCroary - You articulated that well. As the population becomes more comorbid and multi morbid, more chronically degenerative, more complex and older and more complicated, I think it is the only way to manage that. Having that understanding is so important as these organisations move forward, isn't it? You mentioned where and how do we find and encourage the champions of the future. I note you work with the University of NSW and the Australian General Practice Training program, so I was wondering what drives

and sparks your interest in training the next generation of GPs and where does that come from?

Andrew Knight - I don't do it as much as I did, but I certainly was involved in GP Training. I was the medical educator with the old college training program and then I was involved with establishing WentWest. I was the director of education/training for WentWest and that was a wonderful experience. I find training and learning are what turns many doctors on, and the training practices and community practices we built up were just the best practices and I met many wonderful colleagues over the years. I think it is a way of training the GPs of the future: they need to have a whole set of other skills compared to what we had when I came through. General practice is all about teamwork and a lot of chronic disease, a lot of care moving backwards, isn't it? The pendulum is really swinging because our system just cannot cope. But also, having a registrar at your practice transforms the way you practice and the sense of thinking about what you do. You have a sense of teaching which means you keep up and hone your skills and knowledge. I enjoyed it, Ken, and I found it really inspiring. I find the training practices I have visited across the country have the most inspiring people. They are also, mind you, all the people who went in for the collaboratives and the training practices as well. I don't encourage people to think about training and doing it in a high-quality way. If you have mastered your clinical work, you can really enhance your enjoyment of your practice. Having people flow through and the registrars can bring enthusiasm and a fresh view. You also can do it in a bad way. I have seen people use their registrars as cheap labour. That is throwing away an opportunity. If you do it in a good way and set aside time for teaching and listening to your registrars and seeing them develop, it can be a wonderful way to plug into the wider general practice community. I enjoyed being a medical educator and a supervisor. I was disappointed when the GP Unit stopped having registrars because I enjoyed that part.

Ken McCroary - Yes, that is really cool. And I am sure that the enthusiasm you bring would have inspired quite a few of your registrars to continue that now. It is great when you run into old registrars who are now supervisors and educators, isn't it?

Andrew Knight - Oh absolutely, it is so fun when you get to a more venerable age. (both laughing) One of our students was a medical student with us and he is now a registrar. To see he chose general practice, and he is still really interested in research and academic stuff is really encouraging.

Ken McCroary - Yes, we get that connection with lifelong GP work, where we now have our babies, we have delivered and looked after antenatally and postnatally, having their own babies. But seeing the development of the students and the registrars is really part of the rewards of what we do as well, isn't it?
Looking back with some questions, your biography highlights a busy and complicated sea. How do you balance all of this and how do you continue to stay well?

Andrew Knight - I enjoyed clinical general practice work even though I am not immersed in general practice now, you might say. But I also found if I did it full- time that didn't work for me. Fairly early on, after four or five years of full-time practice, I went into being a half-time GP and a half-time medical educator. I found that worked really well for me. I respect people who do it full-time and I see many people who love it and thrive, but for my personality it didn't work so well. Doing other things worked for me. Being able to do education initially, being able to do governance and then also the quality improvement work, I found this as well as policy worked best for me. It looks busy but it works; it is not as though I have had to do it after hours like a lot of people do. It has been part of my work and I have been paid for it so it has been for me a good and mixed career, and I think you can do that in general practice if you look around for opportunities. At the college program I am sure there would be opportunities for people to do medical education, and then there is always governance opportunities if you are willing to contribute to PHN work, boards or whatever. You can get skills in that way and that can be very enriching. I have had a lot of years at it, Ken, and I need a lot of time to do this stuff. (both laughing)

Ken McCroary - So, it's not just the work/life balance you are talking about; it's also the work/work balance?

Andrew Knight - I am. I am.

Ken McCroary - Yes, cool.

Andrew Knight - It has enabled me to have work/life balance - being a local GP in Katoomba, I could nick out and go to the school presentation days; I was 15 minutes from home so it wasn't a long commute. The medical education stuff didn't involve the really long hours of general practice. Finding what suits and what works for you - that has worked very well for me.

Ken McCroary - Yes, good to hear. I was going to finish up now with a question about your vast experience and different journey through general practice and the peripheral general practice with the other things you have done in education and governance - just looking for some advice for colleagues and especially for trainees and the younger guys on keeping well in their career, enjoying their career and keeping themselves healthy too.

Andrew Knight - That is a really good question. We have all seen people, a lot of GPs, who have burnt out, which is an awful thing to see. General practice is a marathon not a sprint. You must play it for the long-term. I see my colleagues, and I have had some wonderful colleagues over the years, and I think watching them is a useful strategy. I remember turning up as a registrar and thinking "I haven't got a car park for my car", and seeing my supervisor turn up in his old Commodore and I was thinking "okay, he drives a Holden Commodore; he is not driving a Porsche or a BMW". I learnt from him that he valued lifestyle over money and that really was true. He did lots of other things, he had a winery. There was another doctor there that had a farm. I think you can become enslaved to the Ten Commandments of a happy general practice, and I think one of them was "don't expect to live like a dermatologist". Maybe you should quote that! You are not going to be earning half a million bucks a year unless you practice in a funny and different way to me. You have to cut your aspirations to what you will be earning, so you are not a slave to grinding it out to make the income. Another way is to make sure you are happy. For me, I always have enjoyed my work and I think I have made a lot of decisions to make sure I keep enjoying it. I enjoy practice so I will keep practicing; I enjoy being a GP and doing general stuff so I will keep doing that; I also enjoy doing other things and using other parts of my brain. Listen to your partner if you have a partner in life. There were many times when my wife sat me down and said to me: "You can't do this, you have got to stop something.". That was really grounding for me, I took her advice and changed some things, did some things and that made a big difference. A friend once said you only know your limits when you exceed them, and I have experienced that a few times - when you have just added things, added things, added things. Sometimes you coped while other times you knew you'd exceeded your limits and you had to pull back from what you were doing. I could go on and on and on about the things that have helped me to work it out, and it might sound like tripe. At one point I really tried getting to the core of what motivates people and really thinking about what motivates me, what's really important to me, what works best for me. If you reach that point, then it doesn't feel like work. That's the point.

Ken McCroary – Obviously wise council: be aware of your own expectations and facilities, I guess, and if we all find something we enjoy doing then we never have to work a day in our lives, do we?

This has been a real pleasure today, Andrew. Thank you for spending all this time with us and sharing your knowledge and your experience. It's been terrific and I really appreciate your participation. Thank you so much.

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