GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Remembering
Dr John Musgrove, MNZM

Mind This
Expert opinion by
Dr Peter Moodie

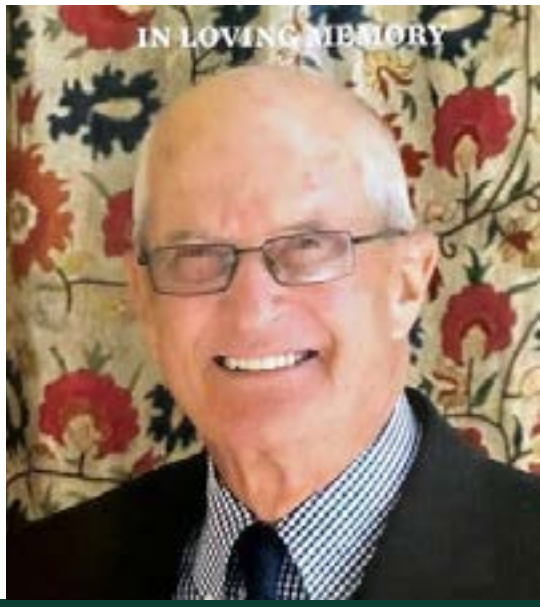
ACC
Clinical or medical
note request

Jono Hoogerbrug
Meet the 2022–23 New Zealand Harkness Fellow

The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

September 2023

In this issue



News from the College

Views of our Fellows

Voices of the Sector

Editorial

Dr Samantha Murton

Welcome to the second edition of *GP Voice*. I hope you're enjoying the refreshed monthly wrap-up of College, member and sector news.

We continue to be incredibly busy with our advocacy work, which is so important with the election now only a couple of weeks away. We're calling for urgent action to address the concerns that we, our practices, and our amazing teams are all facing.

There have been some successes over the month that are worth mentioning. Firstly, **the change to opioid prescribing was reversed back to one-month prescriptions**, and this will come into effect from 5 October. The College was quick to voice our collective disbelief on the regulatory changes and was instrumental in getting this reversal. We are also working with other primary care nursing pay parity campaigning for primary care nursing and have instigated conversations about the inbox deluge with Medical Council, Health and Disability Commissioner, Te Whatu Ora, Manatu Hauora and Medical Protection Society. Watch this space.

The state of the health workforce is also getting the high levels of coverage it deserves. With our patients and communities being the ones who suffer with longer wait times, let's hope their frustrations and our calls for action are putting pressure on government officials to ensure their health manifestos and campaign promises can turn into tangible action and urgent change in the crucial first 100 days of the post-election period.

As we face many struggles it is important to remember how far we have come and what we have achieved even in the last few years. I was reading today that unlike many other countries across the globe we have not had a dip in life expectancy in the last two years. I credit this result with the extraordinary work done by general practice teams for their communities.

As the College celebrates 50 years of training and supporting specialist general practitioners, it is critical to remember that we have made enormous changes and can continue to do so. The training was fledgling, the numbers were small, we had to learn to teach, develop our craft, and hone new skills. We need to harness that boldness and bravery and continue to develop our profession in the way it should go.

Please remember to send through your suggestions of notable College members to interview, milestones to remember and any photos you have that look back on the last half century of the College. Also send through your successes, your ideas for the future, the things you have done differently and the impact you have made. We'd love to share them in upcoming editions of GP Voice and on our social media.

Kia kaha,

Dr Samantha Murton
President | Te Tumu Whakarae

Any questions or publication ideas for GP Voice can be sent through to **communications@rnzcgp.org.nz** and you can keep up to date throughout the month by checking out the College's website under **News + Events** and **Our voice**.

50 years of the College

A moment to reflect on RNZCGP achievements – an interview with Dr Samantha Murton

Zach Thompson

Website Wrangler and Reporter, New Zealand Doctor Rata Aotearoa

The RNZCGP is celebrating its 50th anniversary and will use the coming year to reflect on its achievements and those of its members.

In a video featured in the College newsletter, president Samantha Murton welcomes members to share their favourite stories from the past half-century.

"Part of it is celebrating ourselves, encouraging each other in what we have done and achieved," Dr Murton tells New Zealand Doctor Rata Aotearoa.

The College will use its own social media channels, its magazine *GP Voice* and print material to share the stories it receives.

"We'll also have a wrap-up at the end of the 50th year of all the different stories that have come out… so that people can see where we've gone from and to."

The College's office will feature a display of key milestones from the past five decades.

Dr Murton began her tenure with the College as its first medical director and was voted in as president in December 2018, a moment she says is a personal highlight: "[It was] gratifying that people wanted me to be president."

On achievements during her time as president, Dr Murton says adjusting to the COVID-19 pandemic is one of the things she found most tough, because it involved telling the sector to move to virtual interactions overnight.

However, being able to hold a face-to-face College conference in Wellington during this time was also a big deal, Dr Murton says. "It was a really good buzz that we could get together for that conference."

She describes as "massively successful" the work she did with then-medical director Bryan Betty during the pandemic to give general practice a voice in entities such as the Ministry of Health, Te Aka Whai Ora and Te Whatu Ora.

"There are a number of GPs now involved which has never been the case [before]… There were a few but not to the extent that we have now."

Further, she says getting pay parity for GP registrars was "very good" for the sector.

"[It puts] us on the same footing as any other specialist qualification."

The owl has been a constant element, first on the badge, then on the emblem.

But, given the organisation is an education provider, Dr Murton says the college's teachers are incredibly important.

"[We value the] teachers and the work they do through the GP training programme," she says. "But there's still work to be done to increase our teaching cohort [and] to value all teaching that goes on in general practice."

Looking ahead, Dr Murton recognises the need to constantly evolve with the times and says this means acknowledging that, while current issues will remain, much medical care can be carried out in the community.

"As the needs of the community change, the services and delivery need to change," she says.

"Having a broadly scoped [vision] is really important."

The RNZCGP formed in 1973 and now boasts 5000 members across Aotearoa.

Republished with permission from New Zealand Doctor Rata Aotearoa

50th Anniversary

Video of the College's President Dr Samantha Murton

Policy, Advocacy, and Insights

The College's Policy, Advocacy, and Insights team is your voice on many issues across the sector

In the previous issue of GP Voice, we summarised our research work and listed submissions in progress. This time, we outline the team's tasks in terms of advocacy, position statements and insight reports, to give you a wider perspective on the scope of things we do.

Advocacy

The advocacy aspect of the team's work is done alongside the College's medical director, Dr Luke Bradford. This year, the team has advocated on behalf of members for the following matters:

1. Development of integrated systems that support GPs to deliver continuity of care, with Te Whatu Ora.
2. Sector wide action to develop a system to support people with ADHD, together with ADHD NZ.
3. Ways the College could increase uptake of general practice as a career choice, and barriers to entry, in collaboration with NZMSA.
4. Liaison with Veteran Affairs NZ to identify areas where GPs could increase health and equity for young veterans.
5. Matters concerning ACC: Cost of Treatment Regulations, Concussion guidelines, and Sector Engagement Group.
6. Collaboration with MOH Surgical Mesh Working Group.
7. Meetings with the Minister of Health regarding palliative care.
8. Firearms regulations and a licensing system with Arms Engagement Group of the Police.
9. Telehealth with MCNZ.
10. Collaboration with Oranga Tamariki on the health needs of children in Oranga Tamariki care.
11. The team has discussed members' perspectives and experience with the Independent Children's Monitor.

"We outline the team's tasks in terms of advocacy, position statements and insight reports, to give you a wider perspective on the scope of things we do.

Position statements

This work is continuous, with our positions reviewed as issues emerge, laws change, new evidence appears, and our practice evolves. In February we released a position statement on Nurse Practitioners' contributions to general practice teams. Over the coming months we'll be publishing position statements on tobacco and vaping, climate change and health, rural telehealth, and antibiotic resistance and prescribing.

Insight reports

The team's larger research projects are published as standalone reports. This year it has produced:

- The outcome of the Workforce Survey: 1) 2022 RNZCGP Workforce Survey's Cover paper: Team GP is at Risk; 2) Overview Report 3) Rural Hospital Medicine Report; 4) Time Series Report
- GP Burnout research to understand GP workloads
- Closed Books Research: we provided advice to the Health Services Research Centre, University of Otago and Victoria University of Wellington
- Pharmacists in General Practice Research: the College surveyed general practices to understand the value of clinical pharmacists
- Position Paper regarding Prescribing Medicinal Cannabis

In the October issue of *GP Voice*, we'll take a close look at ongoing work on Specific Interests.

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The team's larger research projects are published as standalone reports.

PMAANZ

The Quality Programmes team at the conference

Lucy Wass

The College's Senior Quality Programmes Advisor

The Quality Programmes team travelled to Ōtautahi Christchurch this month to present and exhibit at the PMAANZ (Practice Managers and Administrators Association of New Zealand) Conference.

The theme of this year's conference was Operation Transition – from Reactive to Proactive. Topical presentations included discussions on innovative approaches to Māori and Pacific health engagement, debt collection for medical centres in a cost-of-living crisis, and cyber security in the health industry.

The workshop

A highlight for the team was the workshop they held on the final day. They led a group of almost 50 participants through an activity on 'creating your persona', as well as discussions on how the Quality team could further serve their customers, and on current pain points within practices' quality journeys.

The team presented on the College's current quality framework given that a lot of the changes were introduced in 2020, in particular to communicate the changed requirements for Cornerstone accreditation which is now much simpler and not as onerous as previous requirements. Participants were also pleased to be the first to hear about the upcoming Foundation Facilitator training (now accepting registrations) and to have the chance to win a Kathmandu voucher.

The feedback

The team also interacted with the 370 attendees, many of whom visited the College stand over the three days. They noticed that there were more practices enquiring about moving towards Cornerstone accreditation and expressing positivity in the programmes than in previous years. They also took note of improvements in the website suggested and sought feedback on the experiences of practices who had recently completed the Cornerstone Equity and CQI modules. Feedback on the modules was largely positive and the team is excited to help guide through more practices in the process in the months ahead.

The conference came to a close with Heidi Bubendorfer, the team's Principal Advisor, receiving recognition from her PMAANZ colleagues for the conclusion of her role as secretary. Heidi received well deserved praise for her five years of service.

The stand of the Quality Programmes team at PMAANZ in Christchurch

The Quality Programmes team: Carrie Hetherington (left), Lucy Wass (middle) and Sandhaya (Sandy) Bhawan (right)

Lucy Wass leading the activity on 'creating your persona'

Spotlight on Te Akoranga a Māui

A brief introduction of the Chapter

Te Akoranga a Māui is 21 this month. It was launched at the 2002 conference in Rotorua, becoming the first Māori representative group within a professional college.

The late Dr Paratene Ngata (Ngāti Porou), was the orator that year, giving an oration that invoked the mana of Maui Pomare, Sir Peter Buck, Tutere Wirepa and Ned Ellison, the original members of the Māori Medical Practitioners Society at the beginning of the 1900s.

Dr Ngata said "It's taken us 100 years. It's amazing, our children and our grandchildren are going to see the benefits of building such strong relationships."

This recognition of the past was echoed by Dr Rachel Mackie (Ngātiwai) when she became Chair of Te Akoranga a Māui in July 2020. "My goal is to continue the work of the people who've gone before us, like Dr Sue Crengle, Dr Lily Fraser, and Dr Melanie Wi Repa to keep building towards health care equity."

Now chaired by Dr Jason Tuhoe (Hauraki, Ngā Puhi) , Te Akoranga a Māui has over 200 members and continues to fulfil Dr Ngata's expectation of benefits. It advocates for equitable health outcomes for Māori and plays a significant role in providing a cohesive space that recognises the differential experiences of Māori across their educational development and medical career.

Two members of Te Akoranga a Māui received the President's Service Medal at the 2023 Fellowship and Award ceremony. The medal recognises an outstanding contribution to the College or the Division of Rural Hospital Medicine.

Dr Jacqueline Sherburd Te Makahi Allan (Kati Mamoe ki Rakiura, Kai Tahu) is a founding member of Te Akoranga a Māui. Her medal recognises dedication to training the next generation of general practitioners. She shares her knowledge with Māori and Pasifika GP registrars through mentoring and as an in-practice teacher. She set up mock examinations for Māori and Pasifika registrars in her Auckland clinic with the support of her clinical staff and patients. The success of this initiative grew from Dr Allan's time as a teacher and as a contributing member of the College's clinical examinations.

College President Dr Samantha Murton said, "Dr Allan's dedication to supporting Māori trainees has gone a long way to ensuring our GP and rural hospital medicine workforce truly represent the diversity of Aotearoa New Zealand's population."

Dr Jacqueline Sherburd Te Makahi Allan receiving the President's Service Medal from the College President Dr Samantha Murton at GP23

Dr Helena Atareta Paki Haggie is an active member of Te Akoranga a Māui. Her medal recognises her work in governance, community health care, and hospital-based cardiac care.

As a co-opted member to the Executive Committee of the Council of Medical Colleges, Dr Haggie contributed to the Cultural Safety Framework that was launched earlier this year in partnership with Te Ohu Rata o Aotearoa (Te ORA). The framework is being implemented across all Australasian and New Zealand medical colleges with the aim of having a significantly positive impact for Māori health in Aotearoa.

Dr Haggie continues to work in her community providing healthcare and advice in school-based clinics in the Waikato region. She was also involved in the mahi to improve cardiac care within Waikato hospital.

College President Dr Samantha Murton said, "Dr Haggie's desire to improve health equity for Māori led her into governance roles where she can ensure the voices of the GP workforce, and of Māori, are being heard.

"Her part in the development of the Cultural Safety Framework, which I got to see firsthand, will have a significant benefit to the health system and Māori heath across Aotearoa."

Dr Helena Atareta Paki Haggie receiving the President's Service Medal from the College President Dr Samantha Murton at GP23

Faculty events

Know what's happening where

1. **The Northland Faculty** will be holding their AGM and dinner at the Comfort Hotel Flames in Onerahi, Whangarei on Saturday 14 October 2023. Ride in a Classic Car with the Whangarei Classic and Sports Car Club before the AGM and Dinner. Register **here**
2. **The Auckland Faculty** together with the Goodfellow Unit and Te Whatu Ora Counties Manukau are pleased to present a free CPD *Mental Health and Addictions* Day on Saturday 14 October 2023. Register **here**
3. **Waikato/Bay of Plenty Faculty** - Registrations close soon for the *Mentoring skills for GPs* workshop in Hamilton (14 October) and Tauranga (15 October) for anyone who is involved or would like to be involved in GP education and/or mentorship. Register by 29 September: for the Hamilton workshop **here** and for the Tauranga workshop **here**
4. **The Otago Faculty** warmly invite you to RSVP to an opportunity to hear College Medical Director Luke Bradford speak on Thursday 19 October 2023 at the faculty AGM and dinner. Please **RSVP by 12 October 2023**
5. **The Hawke's Bay Faculty** warmly invites members to their Annual General Meeting and dinner for a collegial gathering on Wednesday 1 November 2023 at The Chapel, Mission Estate Winery. Please **RSVP by 25 October 2023**
6. **The Canterbury Faculty** warmly invite members to attend the faculty's annual general meeting and dinner on Friday 3 November 2023 at the Ilex in the Botanic Gardens. The event is free to attend for all College members. Please **RSVP before 27 October 2023**
7. **The Taranaki Faculty** warmly invites you to join us at the 'Coastal Five', the locally run event with five different running events on the weekend of Saturday 18 and Sunday 19 November 2023. For further information about the 20% registration discount for Taranaki Faculty members, please contact **taranakifaculty@rnzcgp.org.nz** or click links: **The Coastal Five**, **The Devon Mile**, **Active Kids**

ACC

Clinical or medical notes requests

At a recent meeting with ACC, Dr Luke Bradford raised concerns on behalf of College members about a rising trend of long-term clinical notes requests. Several examples were provided, which the ACC team reviewed. This review has indicated a need to take some corrective actions.

ACC may request clinical records to help inform cover and treatment decisions, as well as inform requests for services including pain management, weekly compensation, and home help.

ACC may also request longer-term clinical records to assist in the assessment of backdated entitlements. For example, for a 'loss of potential earnings' claim where treatment was received for a mental injury at an earlier period and the mental injury was the cause of the client's incapacity for work.

All requests for clinical records must be justified and reasonable and have obtained informed client consent.

ACC recognises that this can be an onerous task for the practice, can elevate privacy risks and could impact clients who review their own medical notes.

ACC is therefore undertaking the following corrective actions:

- All ACC staff are required to complete a training module on protection of sensitive information.
- ACC is undertaking a review of the guidelines for information that can be requested to assess backdated entitlements.
- All ACC Recovery Teams (who request backdated medical information) have completed a 'Requesting Clinical Records' capability building session. This session shared feedback from GPs and reinforced the ACC policy.
- ACC is monitoring clinical notes requests to ensure consistency with policy.

ACC contracts with Konnect NET to provide the Sure Med system to facilitate clinical notes requests and manage the payments for this work.

ACC recommends if a practice receives a clinical notes request that they deem unreasonable that they raise their concerns via the Konnect NET system. The appropriate Team Leader will then contact the practice to discuss.

If there is considerable time involved and a practice feels that the listed rates do not cover their time, they can advise Konnect Net of this. Their team will then liaise with the ACC staff member who requested the clinical notes. If the long-term clinical notes request is still required, the fee request is referred to ACC's portfolio team for review and approval.

> "This review has indicated a need to take some corrective actions.

The College and ACC are working together to monitor the long-term clinical notes request process.

Please contact the College Medical Director **Dr Luke Bradford** if you have any concerns or further examples of how this process could be improved.

Dr John Musgrove, MNZM

27 January 1931 – 23 August 2023

Farewell to the former president of the College

Members of the Canterbury Faculty have been reflecting on the extraordinary life of Dr John Musgrove, and send their sincere condolences to his family.

Dr Jonathan Pascoe, a GP colleague and friend, has written the following piece about the life of Dr Musgrove, on behalf of the Canterbury Faculty:

Early career

John Musgrove graduated Bachelor of Medicine and Bachelor of Surgery at Otago in 1955, Diploma of Child Health in London 1962, FRCGP 1973, FRNZCGP 1974 and subsequently FRNZCGP with Distinction in 2000. After being educated in Christchurch, he went to Otago University Medical School in 1950, was involved in the OU Medical Students Association, and was on the Knox College Students Committee. In 1953 and 1954, John was a New Zealand University Rowing Blue.

As a 6th year medical student, John was awarded the Ardagh Memorial Prize as the most outstanding final year student at Christchurch Hospital. He then had two years as a house surgeon before going into general practice in Christchurch from 1958-2003 with some gaps in between.

In 1958, John started practice with Dr Nicol in Clyde Road and also at his surgery in his home at 181 Greers Road. Between 1961 and 1962, John travelled to the UK with his wife Olwyn and children Felicity and Richard for further paediatric training and study before returning to New Zealand.

In 1963, he attended a course in Christchurch by Professor Helm Stierlen, a psychologist from the National Institute of Health, Washington, D.C. This led to the formation of two Balint Groups in Christchurch which functioned for twenty years and gave general practitioners confidence to recognise that their own feelings were important when dealing with patients.

Creating RNZCGP

Between 1969 and 1970, John became chairman of the Education Committee, Canterbury Faculty RCGP and as mentioned previously, he and Ross Moon founded the Ilam Medical Centre which was also a teaching practice for the Christchurch Clinical School of Medicine.

John was instrumental in the setting up of the Royal New Zealand College of General Practitioners following a remit that he presented with Dr Cleve

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> In 1992 John became president of the Canterbury Division of the NZMA, and in 1996 became the President of the College.

Sheppard to the New Zealand Council of the UK-based Royal College of General Practitioners (RCGP).

This initiated a four-year process of forming a New Zealand College, subsequently the Royal New Zealand College of General Practitioners , with a triumvirate of John Puddle (Registrar at the Engineering School Canterbury University), Richard Cartwright (Secretary of the New Zealand Council RCGP) and John (Chairman of the New Zealand Council RCGP).

Working overseas

In 1975, John was the first Merck Sharp and Dohme Fellow, and was able to visit Departments of General Practice/Family Medicine in Canada, the U.S., the UK and Singapore. Three years later with Professor Carmichael, Professor of Family Medicine at the University of Miami in Florida, John set up New Zealand Teaching Fellowships for 12 NZ general practitioners to spend three months teaching in Professor Carmichael's department. All the fellows contributed to the RNZCGP and to teaching general practice in New Zealand.

In 1992 John became president of the Canterbury Division of the NZMA, and in 1996 became the President of the College.

Throughout these years John was deeply involved in teaching in General Practice. He was organiser of general practice teaching in the Christchurch School of Medicine and in the Department of Paediatrics. In 1979, he was the New Zealand Teaching Fellow in Department of Family Medicine University of Miami.

Then in the 1980s, John resigned from the Ilam Medical Centre and spent six years helping to develop general practice training in the Middle East. He was Associate Professor in Family and Community Health at King Faisal University in Saudi Arabia, followed by becoming Foundation Professor, Family and Community Health, at Sultan Qaboos University in the Sultanate of Oman.

Back in New Zealand

On his return to Christchurch in 1990, John set up the Mansfield Health Centre in Merivale with Dr Leigh Hooper. Since then, John held various positions including Medical Officer and Adviser to Nurse Maude Association, and Chairman of the Canterbury Branch of the National Heart Foundation. He initiated a working party to raise funds to create a Chair of General Practice at the Christchurch School of Medicine, was Chairman of the Pegasus Health Benevolent Fund Committee, Assessor for ACC Independent Allowances, Advisor in general practice to the Health and Disability Commissioner, and was a member, then Chairman of the Windsor House Board of Governors.

It is hard to imagine how John found time for all this. Clearly it would not have been possible without Olwyn at his side, particularly with her nursing and social work experience. In 2010, John was deservedly named a Member of the New Zealand Order of Merit in recognition of his services to Community Medicine.

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In 2010, John was deservedly named a Member of the New Zealand Order of Merit in recognition of his services to Community Medicine.

John continued to remain interested in academic medicine and he kept up with his continuing medical education requirements into his seventies. John has been a tour de force in the ongoing development of general practice and in the personal care of his patients whom he has served for many years with humility, compassion and modesty.

We have lost a colleague of the highest calibre, enthusiasm and drive

In 1926, almost a hundred years ago, Sir Archibold Garrod, an English physician and Regius Professor of Medicine at the University of Oxford between 1920 and 1927, wrote in the British Medical Journal what he thought made a good doctor.

The Good Doctor needs to be equipped with tact, resourcefulness, courage, and prudence.

He must have patience with fads, considerateness for his patients and their friends, sympathy with suffering, and gentleness of touch and voice.

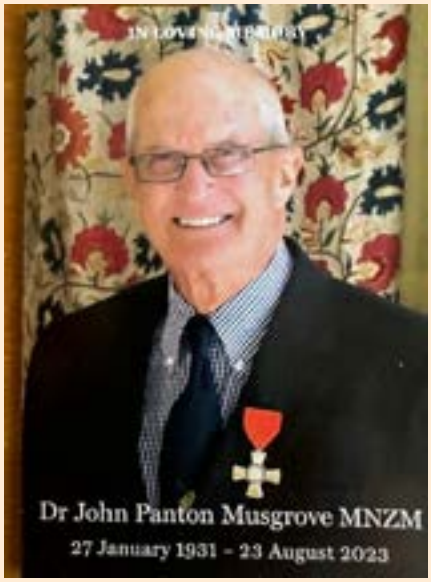
Much indeed is asked of him, but without these qualities, be he never so able, he will make but a poor practitioner.

John had all these qualities.

Rest in peace John.

This is Dr David Gray, Dr Jonathan Pascoe, Dr Ross Moon and Dr John Musgrove on the far Right, IMC partners, in 1986

> “We have lost a colleague of the highest calibre, enthusiasm and drive.



Dr John Panton MUSGROVE

On August 23, 2023, John died peacefully at Holly Lea Care Centre, aged 92 years. Dearly loved husband of Olwyn, loved father and father-in-law of Felicity, and Richard and Fiona, treasured Grandpa of Mason and Sophie, and loved brother of Roger. Loved and respected by his many friends and colleagues. Sincere thanks to the staff of Holly Lea Care Centre for their care. Messages may be addressed to The Family of the late Dr John Musgrove, c/- PO Box 39001, Christchurch 8545.

Memories and condolences for Dr John Musgrove can be left **here**.

MIND THIS

HDC lump in neck

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The case

On the Saturday 24 February 2018, Mrs A was seen at an emergency department after suffering an injury to her shoulder. She had an X-ray and a CT scan, neither of which showed any fractures. She was discharged with a diagnosis of a soft tissue injury only, and told to see her own Dr B on Monday 26 February.

A discharge summary was sent to Dr B on 24 February, and was subsequently amended and resent later that same day. On Monday 26 February the discharge summary was again amended and sent at 11.50 am.

Dr B agreed that he had seen and read the first two discharge summaries but he said that he thought the third was just a repeat and so he filed it without checking it. Mind this: it is likely that he actioned the first two and possibly the third, all on the Monday.

Amendments to the discharge summary

The third amendment had two important details in it:

The first new detail was that the CT scan had been now formally reported and there was a coincidental but suspicious 17 mm lesion in Mrs A's neck. It was advised that an ENT opinion should be sought. The second detail was a note from an un-named clinician which read:

"I have discussed this CT result with Dr B who will organise ENT follow up for Mrs A. I couldn't get hold of Mrs A on her phone".

What followed

Mrs A was seen in the morning of 26 February as arranged, and the case notes make no reference to the CT scan or the suspicious lesion. She was treated for her hip pain and an ACC certificate issued.

In 2020 Mrs A attended an accident and emergency clinic, again with a sore hip. The CT scan report was seen and she was told about the neck lesion and referred to ENT. The lesion was found to be a metastatic squamous cell carcinoma.

Inevitably Dr B was criticised and censured for not reading the third discharge summary carefully and for not acting on the phone call from the hospital clinician. Dr B was adamant that he never received the clinician's phone call,

and explained that he never accepts calls on the weekends, so the call had to have come in before 11.50 am on 26 September. He further explained that he could show that he was consulting from 9.00am that morning. What is more, he saw Mrs A in that same period and it beggared belief that he would have overlooked the advice.

What are the possible scenarios?

- Dr B was recalling details which had occurred some 2 ½ years previously and he may have been mistaken.
- The hospital clinician wrote what he intended to do rather than what he did.
- Although very unlikely, the clinician might have rung the wrong doctor.

One further point, which was not made by Commissioner, is that when discharge or other documents are transmitted and then amended, there should be a very clear warning that there is new information in the documents. If these had been amended instructions to an airline pilot and it resulted in a "near miss" or even a crash, I suspect that there would quickly be a nationwide management policy on how amended documents should be transmitted.

> "Dr B was criticised and censured for not reading the third discharge summary carefully.

MESSAGE FROM MEDICAL DIRECTOR DR LUKE BRADFORD

In response to the issue of amended discharge summaries and the cc'ing of results by secondary care clinicians to GPs without a formal transfer of care, the College has organised a conversation with MCNZ, HDC, Manatū Hauora and Te Whatu Ora. This conversation will address the clinical risk and administrative burden of this unsolicited non-communicated workload and will drive for a change in current practices.

Have an opinion?

Make your voice heard

Join the conversation and leave a comment under **MIND THIS** posts:

@RNZCGP

Meet Jono Hoogerbrug

Interview with 2022–23 New Zealand Harkness Fellow in Health Care Policy and Practice

Tell us a bit about yourself background?

I grew up on Auckland's North Shore where my father, Dr Michael Hoogerbrug, also practises as a GP. After graduating in 2012 with an MBChB from Otago University, I spent almost four years at Bay of Plenty DHB and completed a Diploma of Paediatrics from the University of Auckland.

I went on to start my General Practice training in Auckland and was concurrently the GP Innovation Fellow at Waitematā DHB. I completed my GP Fellowship at the beginning of 2020.

Where were you working before you took up the fellowship and what prompted you to apply?

During the COVID-19 outbreak I was practising as a GP in Auckland, and worked at the Northern Region Health Coordination Centre and in the Ministry of Health's national Covid Vaccine and Immunisation Program. At the latter, I was part of several teams that supported quality, safety and digital products.

This experience exposed me to making an impact on healthcare at the systems level. During my time at the Ministry, I worked alongside several amazing mentors and previous Harkness fellows who encouraged me to apply.

How did you end up at Stanford and what were you working on? What skills did you hope to gain?

Following my experience working on national digital projects in New Zealand, I was interested in Stanford University and its proximity to Silicon Valley. However, my interests ended up focusing on the field of Organisational Behaviour in healthcare. It's about understanding individual and group dynamics within organisations, with my particular interest in clinical leadership.

After discussions with major health systems such as Intermountain Health and the Mayo Clinic, I found leadership to be one of the most influential factors in shaping great organisational culture; and when done well, is an incredibly powerful tool. Unfortunately, in my opinion, not enough energy is given to clinicians developing leadership skills in New Zealand, as it is often assumed leadership comes only with tenure.

So, to help bridge this gap, I've presented my findings in the form of a podcast following a series of conversations. We explore stories and practical insights from renowned experts to drive change and empower clinicians to thrive. It's called Clinical Changemakers.

> "Not enough energy is given to clinicians developing leadership skills in New Zealand.

Anything surprising or unexpected about your Stanford experience?

While there may be some stark cultural and political differences in how we approach healthcare, I found at the core we have a lot of common ground. The culture in the US around entrepreneurship, global collaboration and healthcare at scale is definitely something we should foster here. Ultimately, I was surprised by how much we Kiwis can, and should, contribute to matters of healthcare on the world stage.

What are some of the challenges you've faced with relocating overseas?

While we were well supported, we did choose to live in the Bay Area of San Francisco, which meant a high cost of living. Still, we managed to find an amazing home for the year and explore regularly. Our biggest relocation challenge to date was relocating our dog and getting him home!

Did you take family or a partner with you, and how has that worked out?

My wife, four month old son and dog all relocated together last August. It does take a bit of planning but has been an incredible experience for myself and my family. I've had plenty of flexibility with my work and had the ability to travel both for professional development and leisure.

What do you think the major benefit will be in terms of the skills and knowledge you bring back with you? How do you hope to apply these in practice?

This has been an incredible year to think deeply about healthcare - which is seldom the case in a healthcare career! I've come to learn that clinical leadership is a distinct skill, with a rich academic and applied background, which requires comprehensive training and practice. In addition, I've learnt that as a professional group we must live up to our values, and ensure we don't get captured by our own interests, or of others. And finally, we must use our privileged position in healthcare to advocate and elevate the voices of others.

What would your advice be to others who are interested in an opportunity like this?

It's absolutely worthwhile and has been a life changing professional experience. If you need a sign, this is it: submit your application!

I found speaking to previous Harkness Fellows very helpful throughout the application and transition process. I'd be happy to **connect** with any curious applicants.

Learn more about **Harkness Fellowship**

> "I was surprised by how much we Kiwis can, and should, contribute to matters of healthcare on the world stage.

Cervical Screening Awareness Month

Changes to the the cervical screening programme

Emily Cavana

GP, Medical Educator and advisor to the National Screening Unit

1–30 September 2023

Cervical Screening Awareness Month is an opportunity for me to think about what has been and what is to come in the cervical screening space. As the College representative on the National Cervical Screening Action and Advisory Rōpu, I am excited about the changes to the programme that took effect on 12 September 2023, with the transition to HPV primary screening and the capacity to self-test.

These changes are an opportunity for Aotearoa to work towards eradication of cervical cancer for all wāhine and whānau with a cervix.

As a primary healthcare workforce, we need to harness the potential of these changes. Aotearoa has 180 cases of cervical cancer diagnosed every year, with 85% of these people significantly under-screened or never screened. Māori and Pacific peoples are overrepresented. Increased screening alongside increased HPV immunisation are what is needed to work towards a decrease in these numbers.

The C-Word

I first registered the word cervix in the late 80s, as a preteen on a school trip in an art gallery. I saw two older boys sniggering at an oddly shaped sculpture and heard them say it looked like a cervix, I remember feeling uncomfortable and that I was privy to something private and most likely rude. The word “cervix” was in the media because of the Metro magazine article “An unfortunate experiment at national women’s”. By 1990, the impact of this article was felt with the development of the National Cervical Screening Programme.

Towards the late 1990s, I realised I would need a “Pap smear” myself. I wondered what is a “pap” that needs to be “smeared”? During my first cervical screen, I was offered a mirror to view my cervix. This was a mortifying proposition although I accepted and viewed a dark mysterious tunnel of unknown significance.

By the early 2000s, I was on the other end of the speculum. Associated with that “smear test” was a confusing array of equipment, a slide, fixative spray, several brushes and a spatula. STI testing was routine alongside the “smear test”. The switch to liquid based cytology in 2009 was a liberation for patients and clinicians.

Emily Cavana is a GP, a Medical Educator, and a parent of two ginger offspring. She has been a College representative and advisor to the National Screening Unit regarding Cervical Screening since 2014. She is employed by Otago University, Vibe Youth Health Service and the RNZCGP in Wellington.

GP's perspective

Somewhere along the way, I lost the memory of my own confusion and shame around the cervix. The entire process became business as usual. Patients overdue for this test could visit me for something else and find themselves on the examination bed. We would chat while we got that test done.

Sometimes it's easy to forget the person that I was prior to becoming a doctor. That person was a little shy about her lady bits and would never have consented to a cervical screen done by a male practitioner, or one with a med student in the room. The changes to the cervical screening programme are great for the person I was. They are also great for the male GP who can now offer cervical screening during his consult; the transgender man with body dysphoria; the survivor of sexual trauma who has never disclosed this but has avoided the speculum examination for years; the postmenopausal person who has found the speculum exam increasingly uncomfortable. It is even great for the busy female GP and for my patient overdue a cervical screen. The list could go on and on.

Take-home message

The changes to the cervical screening programme make it a more acceptable medical test, and a better pre-cancer population screening test.

There are, however, three things that I need to say to that person before they agree to the improved cervical screen:

1. Most people who do a self-test will be clear of the virus, and won't need to do another test for five years. I will keep their information on my PMS, and it will also be sent to a national register that will keep their information safe and secure.
2. After doing a self-test, there is a chance people will be called back for a speculum exam or sent straight to the hospital for a colposcopy. These outcomes don't mean cancer, just the presence of a virus that often clears itself, but one that we need to keep a bit of a closer eye on.
3. If people have experienced changes with their cycles, pain levels or anything else that worries them, I still need to know, and they might not be able to do a self-screen.

We have a way to go with cervical screening. This test needs to be universally free. The systems to facilitate people transitioning from primary to secondary care and back again need to be smooth and well communicated.

We have had some wins. It is a better test and it is mana enhancing. The person is doing something for themselves rather than having something done to them. For many people this will only need to occur every five years. With increasing numbers of HPV vaccinated people, we will have decreasing numbers of cervical cancer. We might achieve the success suggested by the World Health Organisation and eradicate cervical cancer. Cervical screening may eventually become a thing of the past.

> “The changes to the cervical screening programme make it a more acceptable medical test, and a better pre-cancer population screening test.

Reaping the rewards of working together

The importance of building authentic relationships with Māori partners was never more evident than during the COVID-19 vaccination rollout, and Mihi Blair – general manager for Māori Health and Equity at healthcare provider ProCare – says good relationships utimately lead to better health outcomes.

ProCare is the largest co-operative network of healthcare professionals in Aotearoa and supports around 850,000 people throughout Tāmaki Makaurau and Te Tai Tokerau. During the COVID vaccination rollout, ProCare worked with numerous organisations to support the campaign and Mihi (Ngāti Whātua) says they quickly learned that while everyone faced different challenges, by working together, many of these could be overcome.

"Our aim was to support Māori organisations with the COVID campaign and to collaborate with iwi, hapū, marae and whānau, kohanga, kura, anyone who could reach our whānau," she says.

"We reached out to many Māori organisations and partners and saw that they had some massive barriers as well."

Working with Māori health collectives in Tāmaki, such as Taumata Kōrero and Te Pae Herenga Waka, immediately revealed ways they could help each other.

"As ProCare, we were able to provide clinical expertise, resources, data and coordination, including human resources and communications. Taumata Kōrero and Te Pae Herenga we were able to provide their outreach, they were able to do innovative things that were able to connect us to whānau."

Mihi says the partnerships they developed during those challenging times taught some important lessons.

"One of the main things that we came away with was, never underestimate the importance of your values and your authenticity when you want to go and work with whānau and Māori providers," she says.

"Be authentic. This can make a difference between you reaching out and you really, truly helping them."

For GPs, she says, recognising and understanding the important role they play in our communities is crucial to forging those relationships.

"They (GPs) are the most important part of the community to effect change for our people. We don't have enough Māori in health at the moment, so they must

> "Never underestimate the importance of your values and your authenticity when you want to go and work with whānau and Māori providers.

step out in the community. It is unacceptable in these complex times that they are still doing things in ways that do not work for our people. Honestly, the best practice that I have seen is when they ask their Māori patients about their community and how that builds whakawhanaungatanga (relationships) and builds the relationship from there."

Being engaged in their communities also means knowing what's going on locally and understanding the impacts it can have on whānau.

"It's not just about the clinical side of things, there are other energies, like what's happening in our communities, on our whenua, those sorts of things need to be taken into account," she says.

"If you invest in our people as a whānau, not as an individual patient, you can see what's happening within the whānau and what you can do to better their health outcomes. And if you're doing that and having a relationship with the whānau themselves, you'll get better communication, increasing health literacy within the whānau - because they're all in it together – and this will actually progress them into better, healthier lives."

Mihi Blair presented *Why building authentic relationships with Māori partners can result in positive health outcomes for communities* at *GP23: the Conference for General Practice* in July 2023.

"Being engaged in their communities also means knowing what's going on locally and understanding the impacts it can have on whānau.

Do you have a story you'd like to share?

Make your voice heard

Submit your article to the Editorial team:

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Challenges in treating people with migraine in Aotearoa New Zealand

Fiona Imlach

MBChB, MPH, PhD

Co-founder of Migraine Foundation Aotearoa New Zealand

The survey

Migraine disease is a debilitating condition estimated to affect 642,000 people in New Zealand, of whom 7-12% have chronic migraine (headache on 15 or more days per month). Little is known about migraine in New Zealand, including use of acute and preventive treatment, acute medication overuse and access to healthcare.

The Migraine in Aotearoa New Zealand Survey attempted to address these knowledge gaps. The survey ran online from August-October in 2022, and collected responses from 530 participants with migraine disease, of whom 22% had chronic migraine.

Key findings

- Almost all (96%) had seen a GP for migraine, most (70%) within the last 12 months. However, 31% had been unable to see a GP for migraine on at least one occasion, most commonly because of long waiting times or being unable to get an appointment.
- Over half of respondents had been unable to see a neurologist, most commonly due to cost or being unable to get an appointment.
- Around half of respondents were taking migraine preventive medication, but at least 74% were eligible for preventive treatment, based on frequency and disability from migraine attacks. Of those eligible, only 57% were currently taking a preventive. 28% had previously taken one (or more) but stopped, mostly because of side effects or lack of efficacy.
- People with chronic migraine had previously used an average of four preventives (range 0-12). 28% of those with chronic migraine were not currently taking a preventive.
- Overall, 27% of survey respondents were at risk of medication overuse headache (70% of those with chronic migraine), overusing one or more acute medications in the past month. Around half of those with chronic migraine had overused opioids (on 10 or more days) or NSAIDs (15 or more days), and 71% had overused triptans (10 or more days) in the last month.

Fiona Imlach is a public health physician with a PhD in epidemiology from the University of Otago, Wellington. She has worked as a researcher in various settings and on a range of topics, including primary health care, inequalities, child poverty, mental health, alcohol and cancer. With two others, Fiona co-founded Migraine Foundation Aotearoa New Zealand in 2022, a charity formed to raise awareness of the impact of migraine disease and support people living with migraine in Aotearoa New Zealand.

What this means for GPs

GPs are the first point of call for the vast majority of people with migraine. Most cases of migraine can be managed in primary care, with specialist referral reserved for those with diagnostic ambiguity or migraine that is difficult to treat or complicated by other conditions. In this survey, respondents had a high level of migraine-related disability, and many had signs of refractory or difficult-to-treat migraine, such as medication overuse and failure of preventive medications.

However, many survey respondents were unable to receive neurologist care. This means that GPs may have to accommodate the unmet need of people with disabling migraine who cannot afford or access private neurologists.

Appropriate **acute treatment** is important to reduce the risk of **medication overuse headache** and the progression of episodic to chronic migraine. All patients with migraine need to be warned about acute medication overuse and the recommended limits on these medications. Opioids for migraine attacks should be avoided and used sparingly (e.g. as 'rescue' treatment in severe attacks not responsive to other medications).

Preventive medication should be considered in all patients with four or more attacks a month or severe, uncontrolled attacks but it can take eight weeks or more (at the maximally tolerated dose) to see an effect. Botox can be an effective treatment for chronic migraine but is rarely accessible in the public system. Several migraine-specific preventives (CGRP antagonists) are available in New Zealand which have fewer side effects and are effective even with medication overuse, but are not funded.

This survey did not capture experiences of people with migraine disease who have not been diagnosed. Respondents reported an average of six years from first symptoms to diagnosis. There is likely much more unmet need in patients who do not yet know they have migraine disease.

> "GPs may have to accommodate the unmet need of people with disabling migraine who cannot afford or access private neurologists.

Cerebral Palsy

Through the Lifespan

Amy Hogan

Advocate, lecturer, panellist, and keynote speaker
The Cerebral Palsy Society of New Zealand

Cerebral palsy (CP) is a complex condition that has unique challenges at each stage of life. Many different resources, interventions and care plans may be involved to meet individual needs. Recently, the CP community was gifted a Te Reo term that encompasses all these elements: **Hōkai Nukurangi** which means 'to achieve what is important to you whatever your circumstances or the way you move or exist in the world'.

Health professionals, researchers and the CP community are working hard to embody these principles for everyone with CP across their lifespan. This article is a brief overview of the work to date and the role GPs can play.

The CP Society provides national support in the form of advice, advocacy ministerial engagement, and funding. GPs may not see many people living with CP in their practice, but when they do, support and resources are available to embody a strength-based approach.

Key events happening in the health setting

1. A more sophisticated understanding of an early diagnosis pathway is developing so health professionals have the ability to identify the early warning signs of CP in both infants that are premature and those that are born full term. Clinicians are working to design and implement an '**At Risk of Cerebral Palsy Pathway**' meaning a targeted surveillance for hip and respiratory health and therapy interventions can begin at an earlier age or stage.

2. A focus on key lifespan transition points. An important element is identifying the transition between different medical services, since it is not as black and white as moving from the paediatric to adult services. For many people with CP, transition between services happens in smaller ways leading up to leaving paediatrics, e.g. seeing new specialists. Starship's website is currently **hosting transition resources specific for CP**.

3. Globally, there has been a concentrated effort to develop a broad understanding of living with CP as an adult. When you live with a lifelong condition, GPs and primary health carers can often be the only constant in a person's health journey. They play a vital role in sign posting areas for investigation with a holistic view. There are unique challenges to health and mobility that CP presents that are different from the general population.

Amy Hogan is a New Zealand–based advocate with 15 years of experience in national disability research projects. She lives with cerebral palsy (CP), which has driven her work at the Cerebral Palsy Society of New Zealand, where she's contributed to research, policy advocacy, and system change. Currently, she's pursuing a Masters in Critical Health Psychology, with her thesis on the language used in purported treatments and cures submitted in August 2023. Alongside this, she's been a lecturer, panellist, and keynote speaker, sharing her expertise with diverse audiences, including government officials, academics, and community groups. Her mission is to bring her unique blend of personal and professional experiences to international platforms, focusing on health and social justice.

We are fortunate to now have New Zealand-specific information to guide health support. This includes data that draws from the New Zealand CP Register which captures broad population figures. There are several research studies looking at specific elements in living with CP such as respiratory and oral health.

Points to consider for CP patients

- Is your practice and waiting room easily accessible?
- Do you know where accessible specialists are such as dental and radiology?
- Review documentation so you are aware of infant risk factors for early referral to Child Development and Specialist services.
- Remember to see beyond the disability to ensure your CP patient is included in all public health surveillance, such as breast screening.

Journal OF PRIMARY HEALTH CARE

The *JPHC* is a peer-reviewed quarterly journal that is supported by the College. *JPHC* publishes original research that is relevant to New Zealand, Australia, and Pacific nations, with a strong focus on Māori and Pasifika health issues.

Members receive each issue direct to their in-box. For between issue reading, visit the online early section.

The early articles include an update on eating behaviour, body image, and mental health in adolescents; developing a model for primary care quality improvement; and patient representation in case-based teaching.

Trending articles:

1. Addressing rheumatic fever inequities in Aotearoa New Zealand: a scoping review of prevention interventions
2. Characteristics and gender affirming healthcare needs of transgender and non-binary students starting hormone therapy in a student health service in Aotearoa New Zealand
3. New Zealand pharmacists' views regarding the current prescribing courses: questionnaire survey
4. Do patients with mental health and substance use conditions experience discrimination and diagnostic overshadowing in primary care in Aotearoa New Zealand? Results from a national online survey

Supporting older people

Nikki Hurst

Kaiwhakahaere Matua | Executive Officer
New Zealand Council of Christian Social Services

Aging population

Current projections are that by 2031, a quarter of Aotearoa's population will be over the age of 65. Our healthcare landscape will soon be dominated by our rapidly ageing population. To navigate this change in service and support, the New Zealand Council of Christian Social Services (NZCCSS) has released **Te Kōrero mō ngā Kaumātua**. This guide is designed to be a user-friendly environmental scan of the context of older people in New Zealand. It is also an urgent call-to-action to address the many gaps in the infrastructure, policies and services which support older people.

Te Kōrero mō ngā Kaumātua aims to increase knowledge and awareness for professionals and whānau who work with and support older people in their communities. Written as a comprehensive one-stop-shop of information, it covers key areas such as the continuum of care, clear definitions of the kinds of ageism facing our older population, and accessible overviews of current policy and research.

Key findings

As well as the wealth of information of what is available, the report highlights what is not. We found that the specific needs of older people are generally not considered in government policies and planning. Where accepted best practice may exist, nationally we lack the infrastructure for implementation. For example, Ageing in Place is of huge benefit for older people, but without appropriate housing, transport, services and community support, remaining in your own home can lead to social isolation which negatively impacts wellbeing.

Furthermore, we found that much of the workforce who will support older people, do not receive specific training on this age stage, or where that training exists is largely in the pre-degree space. This leaves a noticeable gap at Bachelor level that impacts the ability to grow a workforce able to evaluate and reflect critically on their practice.

We are continuing to investigate and advocate for solutions to the major and impactful gaps the guide has highlighted. Workforce, funding and scarcity are key – being visible examples of the continuing impact of ageism. We need an intense, cross-governmental, cross-societal focus on how we meet this challenge as well as learning from the opportunities that exist.

Nikki Hurst is a Kaiwhakahaere Matua | Executive Officer of NZCCSS which represents 230 community, health and social service providers nationally. She brings to this conversation a varied background in accountancy, service in community and social services NGOs, and academia - particularly youth development and health promotion.

About NZCCSS

Informing the guide is the nearly sixty years that NZCCSS has existed to serve older people across our communities. Our members: the Anglican Care Network, Baptist Churches of New Zealand, Catholic Social Services, Presbyterian Support and the Methodist and Salvation Army Churches make up the bulk of those providing not-for-profit care nationally.

With a membership of over 230 community, health and social service organisations across the motu, we know that there is a significant rise in older people seeking support. We expect you've noticed the same in your work.

We invite you to read **Te Kōrero mō ngā Kaumātua**, share it with colleagues, patients and their whānau.

Please get in touch if you'd like to kōrero further about this work. I'm also available to present our findings at your practice or professional development event. Email: **comms@nzccss.org.nz**.

Further details on NZCCSS can be found on our website **www.nzccss.org.nz**.

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