GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS • TE WHARE TOHU RATA O AOTEAROA •

50 years

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Expert opinion by Dr Peter Moodie

CQI and Equity modules
at Ōtorohanga Medical Center

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

October 2023

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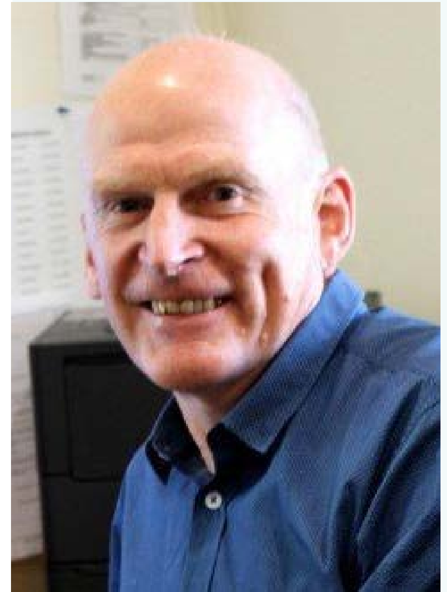

Editorial

Dr Luke Bradford

GP, Medical Director of the College

Dr Luke Bradford

Medical Director | Mātanga Hauora

So the results are in. A new Prime Minister and a new Minister of Health, likely to be Dr Shane Reti who is also a specialist GP. The National Party made some promises throughout the campaign. More medical school placements at Otago and Auckland and of course the big-ticket item of a third medical school to be based in Waikato and open in 2027. We are all waiting to see what changes are implemented within our workforce, and in the health sector as a whole.

We will be requesting a meeting with the new minister, once the post-election dust settles, to convey our top priorities that need to be addressed within primary care. We're curious to hear how the Minister intends to fill this new medical school with students who will go on to choose general practice or rural hospital medicine as their specialty, and how we can work together to showcase the rewarding nature of our role.

This issue of *GP Voice* showcases how the work that you do forms the platform for the work that the College does, as we continue to advocate on your behalf and highlight the complex, comprehensive and crucial work that we do.

There are many ways for you to bring the issues that you are facing as an individual, a practice or a community to the attention of the College. You all belong to a **Faculty** or a **Chapter**, and you'll have a representative from your region on the **National Advisory Council** (NAC). Get in contact with your appropriate rep and have your say about what's going well or what could be done differently.

To carry on celebrating the College's 50th anniversary, we hear from a member who has retired after 48 years. He reflects on his career and the changes he's seen over the decades – many are topics that the College is addressing today: pay parity, collaboration with the wider primary care workforce and burnout.

The changing nature of our role and complexities with patients' health also highlight the importance of keeping up to date and competent in all areas of our work. Dr Peter Moodie's HDC case reviews are a worthwhile read and serve as a reminder to take a look at our own practices and if there is anything we can, or should, be changing to keep ourselves and our patients safe.

If you have anything you'd like to contribute to *GP Voice* , email the team at **communications@rnzcgp.org.nz**

Until next month,

50 years of the College

Looking back at the milestones

The College was officially established on 13 August 1973, when the New Zealand College of General Practitioners (NZCGP) was incorporated as a charity. The incorporation marked independence from the British Royal College of General Practitioners, which operated a New Zealand Council from 1957.

The College held a foundation dinner in Christchurch on 24 January 1974, attended by HRH Prince Philip, Duke of Edinburgh who became the College's patron. The College's inaugural conference which was held in Christchurch in 1974 was attended by 299 registrants, with about a third coming from overseas. In 1979, Queen Elizabeth II granted the Royal Charter, making us The Royal New Zealand College of General Practitioners. Prince Philip became the first Honorary Fellow of the College in 1981.

The College has continued to be first in its field. The first medical college in New Zealand. The first professional college to establish a Māori representative group. With its *Aiming for Excellence in General Practice* established in 2000, the College continued to set standards for GPs, and to advocate on their behalf. In 2020, the College supported members through the COVID-19 pandemic via regular email updates, webinars, and a dedicated website. The College was quick, responsive, and accurate, and answered more than 750 COVID-19 queries within the first two months.

Watch how the College grew and changed over the last 50 years:

Pay parity for nurses

The College joined a collective advocacy

Simone White

Senior Communications Advisor at the College

Joint advocacy

A significant piece of joint advocacy has recently been undertaken, calling for pay parity between nurses working in primary care and Te Whatu Ora employed nurses. Deciding it was stronger to join forces, 12 organisations, including the College, wrote to the political parties' health and finance spokespeople, asking for their plans, solutions and commitments about how they intend to address the pay gap of 15 to 35%.

The letter was signed by: Whānau Āwhina Plunket, Family Planning, Te Kahu Pairuri o Aotearoa – Hospice New Zealand, Aged Care Association, Home and Community Health Association, Access Community Health/ Hauora Tara-Ā-Whare, Whakarongorau Aotearoa/New Zealand Telehealth Services, General Practice NZ, Hauora Taiwhenua Rural Health Network, General Practice Owners Association of Aotearoa New Zealand, Practice Managers and Administrators Association of New Zealand, and the College.

> “It was stronger to join forces.

The impact

The letter highlighted the impact of the pay parity gap on delivery of essential health services, and how this ultimately puts New Zealanders' health and quality of life at risk. Examples include:

- Whānau Āwhina Plunket has 35 nurse vacancies, potentially affecting 140 Well Child Tamariki Ora core contacts to pēpi and tamariki every day.
- Some of the 30 Family Planning clinics had to close for multiple days during August because of a lack of staff.
- General practices nationwide are being forced to reduce services and opening hours.
- More than 1000 aged-care beds have been closed permanently.
- A number of hospices have reduced their inpatient beds.

Speaking up

While the group wholeheartedly endorses the recent historic pay equity settlement for Te Whatu Ora nurses and health care workers, it has created a stark pay gap with those working in primary, community, and telehealth care. “Collectively we represent services that support New Zealanders from cradle to grave. We've come together for the first time because we fear communities

are missing out on critical health care," said Fiona Kingsford, chief executive, Whānau Āwhina Plunket in the joint media statement.

This was echoed by College President Dr Samantha Murton who said, "Our community, primary care, and telehealth nurses and health workers care for and treat millions of New Zealanders, including our most vulnerable elderly, hapū māmā, pēpi and tamariki, and those who are dying. When our services begin to crumple, these people are forced into an already overrun hospital system that is also at its breaking point."

You can show your support for pay parity for nurses and health care workers within primary, community and telehealth care by downloading this badge and using it on your social media pages.

Faculty events

Know what's happening where

1. **Tairāwhiti Sub-Faculty** invites all faculty members to attend the Tairāwhiti (Gisborne) Sub-Faculty Annual General Meeting on Tuesday, 31 October, 6.30 pm at The Works Restaurant in Gisborne.
2. **Hawke's Bay Faculty** warmly invites members to their Annual General Meeting and dinner for a collegial gathering on Wednesday, 1 November, 6 pm at The Chapel of Mission Estate Winery.
3. **The Canterbury Faculty** invites to attend the faculty's annual general meeting and dinner on Friday, 3 November, at Ilex in the Botanic Gardens. The event is free to attend for all College members. Please RSVP before 27 October 2023
4. **Southland Faculty** invites you to join us in beautiful Te Anau for the 6th Southland GP Continuing Medical Education weekend on 4–5 November. For further details and to register, please visit the Well South website
5. **The Taranaki Faculty** warmly invites you to join them at the 'Coastal Five', the locally run event with five different running events on the weekend of 18–19 November. To learn more about the 20% off discount code for Taranaki Faculty members, please contact taranakifaculty@rnzcgp.org.nz or click links: The Coastal Five, The Devon Mile, Active Kids
6. **Waikato/Bay of Plenty Faculty** warmly invites you to attend their Annual General Meeting and Educators Symposium on Saturday, 18 November, at the Novotel Rotorua Lakeside.

   The Educators Symposium will be hosted by two very experienced local GP Medical Educators: Dr Liza Lack and Dr Fiona Whitworth, and highly accomplished presenters from the IM Reasoning podcast – Dr Nicholas Szecket and Dr Art Nahill. Please RSVP before 12 November 2023

Meet Dr Tim Akroyd

Interview with a College teacher

Dr Tim Akroyd, a GP for almost 40 years and a valued teacher, has hung up his stethoscope for the last time and is ready to embark on new adventures. Tim says he feels a deep sense of gratitude for the "blessing" that his career was, and has some parting words of encouragement for his colleagues in primary care.

Twenty-seven years is a long time to work at one practice – how are you feeling now that reality has sunk in and you've stepped back from life as a GP?

I feel rather humbled actually – as the news that I was leaving spread, and I began to say goodbye to my patients and handover their care to my colleagues at Greenwood Medical Centre in Epsom, many people made a point of thanking me and letting me know what the care I have offered has meant to them over the years. It is easy to underestimate the importance of long-term relationships in general practice.

You've been a teacher since Greenwood was established in the mid-90s – what did you enjoy about teaching and what were the benefits to your practice?

Registrars have brought so much to our practice over the years and had a real rejuvenating effect. They bring diverse perspectives and experience and have up-to-date knowledge and skills that help established practices remain relevant. I thoroughly enjoyed teaching and building a team at our practice that had real diversity – three of Greenwood's current partners and three associates were registrars first before joining as permanent members of the team. I'd encourage other practices that aren't currently taking registrars to consider it if they're able, as it is such a mutually beneficial opportunity to share knowledge and build a stronger health care system in New Zealand.

> "I thoroughly enjoyed teaching and building a team at our practice that had real diversity.

What were the main things you aimed to impart to registrars as a teacher and mentor?

Well there were several key things: Firstly, the ability to deal with uncertainty. At times you need to be able to make a decision, one way or another, with some risk that things won't go the way you expect or hope they will. This can be an overwhelming and limiting thing for some junior doctors, and it's an important barrier to overcome in becoming a confident and capable GP. I looked at my role as mentor to help registrars practise in a way that was safe for both them and their patients. The second would be the importance of the therapeutic relationship and not undervaluing the importance of talking to patients and really understanding where they're coming from. Writing a prescription is easy, but being able to act as a sounding board and help patients make informed decisions requires patience and effort and it's an important skill to build when you're starting out.

The past few years have been quite challenging for the profession, particularly through the COVID-19 pandemic – what positive things did you notice about how primary care responded?

It was very challenging, and I really feel as though the younger doctors carried some of us more experienced doctors through that time in many ways. They had such great ability to adapt, be flexible, and embrace new systems and processes. Even in a practical sense, their mastery of the IT systems was a real asset to our practice. I was so pleased to see people pulling together, thinking adaptively, and drawing on one another's unique skills and strengths to come up with solutions.

Why are you optimistic about the future of medicine in New Zealand?

We have incredible diversity of talent in this country and we definitely need to hire and train more doctors to relieve some of the pressure on the system. I am hopeful we will be able to do that and ensure that being a GP continues to be a sustainable career opportunity for all doctors who choose that path. I have been so fortunate to work with a great team of colleagues who have enabled me to have an incredibly rewarding career. I'd like to see all GPs receive the level of opportunity and support that I have received.

"I'd like to see all GPs receive the level of opportunity and support that I have received.

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MIND THIS

HDC: Oesophageal cancer

Dr Peter Moodie

Dr Peter Moodie is the College's Clinical Advisor and the author of the MIND THIS column.

On 10 December 2020, Mrs A visited her usual practice with symptoms such as fatigue, loss of appetite, a 7 kg weight loss over the last two months (she weighed about 40 kg), feeling of cold, tingling limbs, reddened palms and poorly fitting dentures which affected chewing. Mrs A was in her 60s and had a history of high blood pressure and SLE. She was an alcoholic and had been drinking two "stubbies" and a bottle of wine per day for some years, and she had also been a heavy smoker.

Mrs A had been brought in by her husband, and although she had been a member of the practice for some years she had not had regular contact with the practice for five years and indeed her last appointment was three years before then.

The circumstances

On this occasion Mrs A was seen by a short-term experienced locum Dr C who was employed for one to three short afternoon sessions per week and left the practice shortly after, in January 2021. Although Dr C worked part-time, she had no remote access to the practice, nor was she able to access the practice after hours. Furthermore, on the day of the consultation, computer and printing problems meant that she had had to retype several of her case notes from memory and make some of her referrals by fax.

Dr C attributed Mrs A's condition to her alcohol consumption. On examination, she identified an abnormal probably cirrhotic liver, and in addition to blood tests she also ordered an ultrasound of her abdomen. Presumably because of the computer problems, she printed out the ultrasound request and asked practice staff to fax this through to the hospital. The consultation was thorough, as she also identified that Mrs A was due for a mammogram and this was successfully ordered electronically.

Although her notes were subsequently criticised for brevity, they weren't that brief (pages 20/21 HDC report 20HDC02065). Dr C argued that they had almost certainly been retyped and could be well understood by others.

The HDC quoted a Medical Council edict that stated that "added or amended notes should be signed and dated along with the reason for any changes". This direction had plainly been written before the advent of computers.

On 17 December, Dr C reviewed the case and resent the fax for the ultrasound, in case it had not been received by the hospital. She also rang Mrs A about her blood results; however, the HDC noted that the phone call did not include details of what was said.

The ultrasound prioritisation

On 19 December, a radiologist responded to the ultrasound request with an electronic letter and a hard copy, explaining that they had assigned it a category C priority, which meant there would be a delay of up to 38 weeks. There was an invitation to supply more information if Dr C did not agree with these time frames.

Unfortunately, the hospital sent the information to the wrong practice. Somehow (not explained) a hard copy did reach the correct practice on 23 December, but Dr C is adamant that she did not see it and said that for the previous 30 years she had always signed any hard copy as proof that she had seen it, and if she had, she would have rung the radiology department. The practice indeed had a curious method of managing hard copy documents: when received, the letter would be scanned into the computer, the hard copy would be then given to the relevant doctor who reviewed it, annotated it and then gave it back to reception. The letter was then given to another doctor (Dr E) who filed it electronically and the original document was then destroyed.

The practice audit log showed that the hard copy letter was scanned on 23 December and that it was finally filed by Dr E on 28 December. The practice argued that Dr C must have seen it, but the HDC identified that there was no proof that she actually did. As the letter was scanned before it was reviewed, it couldn't have any added comments on it. Dr C finished at the practice in mid-January. Although there were some minor criticisms, her actions were considered to have been reasonable.

> “The practice argued that Dr C must have seen it, but the HDC identified that there was no proof that she actually did.

Another examination

On 31 December 2020, Mrs A was again brought to the practice and seen by Dr B, as her condition was deteriorating. Dr B noted that there had been episodes of melaena, but her bowel motions were now brown. He had read Dr C's notes and, since she had been examined by Dr C three weeks before, he didn't palpate her abdomen, as he felt there was nothing to be gained. His provisional diagnosis was of GORD, and he prescribed omeprazole along with an action plan to review her in four weeks.

He did however record a differential diagnosis of a possible carcinoma (pages 20/21 of the HDC report). He said that he had wanted to admit Mrs A that day, but Mrs A declined as this was on New Year's Eve. Unfortunately, he did not record this in the notes, and Mr A later denied that he had suggested that.

Dr B was criticised for not examining the patient, not recording her haemodynamic status, not organising bloods, and not recording the patient's refusal of admission.

Emergency department

Five days later Mrs A went to an emergency department and was diagnosed with a carcinoma of the oesophagus with both lung and liver metastases. We can assume that the proposed 38-week delay in imaging was not implemented. Mrs A died three weeks later.

Observations

Mrs A fate was sealed well before her consultation on 10 December, and it is unlikely that any earlier intervention on either 10 or 31 December would have made any difference. If, however, Dr B or Dr C had had easier access to imaging tools, the diagnosis could have been made earlier.

It is surprising that there was no criticism of the hospital for sending a report to the wrong practice, as this might well have resulted in an earlier diagnosis. Indeed, this is the second case in recent times where hospital communications have been found wanting.

It is also surprising that a referral for ultrasound in a patient with probable cirrhosis was given such a low priority. Even without it being stated on the referral form, the possibility of malignancy should have been considered.

Learnings

- Invariably, your case notes will be examined in great detail by the HDC. In this case, the hospital notes – possibly with the benefit of hindsight – referred to her having "dysphagia over several weeks". Dr C who saw Mrs A first, stated that there was no suggestion of dysphagia, and if there had been, she would have regarded this as a red flag. Dr B considered GORD as a differential diagnosis and again made no mention of dysphagia. No mention of this symptom was carefully considered by the HDC.
- If a patient declines to accept your advice, you need to document that very clearly.
- In this case the practice had some poor management processes. Other peoples' processes can get you into trouble.

Finally, if you do read the original HDC report (20HDC02065) you may find yourself confused by the dating system used. The first time that Dr C saw the patient is recorded as "10 Month 1", which you might interpret as January 10, but this is not the case. It refers to the 10th day of the first month of the case. The system is flawed from a number of positions: firstly, Month 2 in this case should not start until the 10th of the following month, otherwise the case appears to have dragged on longer than it actually did. Secondly, the dating system should actually start at "Month 0"). The dating system is reputedly used "to protect privacy". However, at various points in the report the true dates are obvious. So much for privacy!

> If a patient declines to accept your advice, you need to document that very clearly.

Have an opinion?

Make your voice heard

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

@RNZCGP

Time for breast screening

Breast cancer awareness month

Dr Janet Hayward and Dr Alison Foster

Breast care GPSIs

October is breast cancer awareness month in New Zealand and around the world. It aims to both raise awareness and funds for research and support of people living with breast cancer. Around the country many landmarks and buildings have turned pink for the month – our local cathedral and clock tower in Nelson among them. New Zealand charities, such as the Breast Cancer Foundation, are running awareness campaigns encouraging women to book their mammograms and to self-examine and "know their normal". As a result, we hope to see more people having screening mammograms and coming to see their GP if they have any concerns about their breasts.

Situation in New Zealand

The statistics are sobering. One in nine New Zealand wāhine will develop breast cancer in their lifetime. It's the most common cancer affecting women in Aotearoa and the third most common cancer overall. The rates are increasing worldwide, and some countries are now reporting a rate of one in seven. Lifestyle factors (such as rising obesity rates, smoking, alcohol consumption, exercise and diet) are likely to be contributing factors. On the other hand, family history due to an inherited pathogenic gene, while important to identify, account for only 5–10% of breast cancers.

BreastScreen Aotearoa (BSA) is New Zealand's free national breast screening programme for women aged 45–69. It is currently an opt-in programme, and it is recognised that general practice has a key role in encouraging women to both enrol and have their mammograms when due. Mammograms make a real difference to survival: 85% of women who find a cancerous breast lump survive 10 years or more, but this increases to 95% of women who have cancer detected through regular mammograms. Most breast cancer (70–75%) is diagnosed over the age of 50, but we are seeing more women diagnosed under the age of 40.

Breast screening rate

The breast screening programme aims for a coverage of 70% of women. Unfortunately, our breast screening coverage rate dropped during the pandemic, with the current coverage as of September 2023 being 66.6% overall. Returning to pre-COVID screening rates and improving access to screening services for wāhine Māori and Pacific women is a priority focus

Dr Janet Hayward is a breast care GPSI at Nelson and Wairau hospitals, and a previous College representative on the National Bowel Cancer Working Group and Bowel Screening Advisory Group.

Dr Alison Foster is a breast care GPSI at Wellington, Hutt and Nelson hospitals, a member of the National Breast Cancer Working Group, and Chair of Clinical Advisory Group Te Rēhita Mate Utaetae, BCF national register.

for BSA. There are several initiatives under way to improve screening access, including upgrading the software technology and co-designing new and innovative ways to deliver breast screening that recognises the complex barriers that prevents women from accessing screening. BSA providers are extending their operating hours, including late nights and weekends, and have implemented additional text message campaigning as a reminder, and to encourage attendance.

And don't forget about men! Around 25 men are diagnosed with breast cancer each year in New Zealand. Trans-women, intersex and non-binary people can also get breast cancer.

Breast medicine

Hot topics in breast medicine include the role of breast density in screening, with additional screening tools such as tomography for women at highest density being considered for the future. This technology is a mammogram add-on, offering increased sensitivity in cancer detection.

Te Aho o te Kahu, the Cancer Control Agency, is working on ways to improve breast cancer care in New Zealand using local data from Te Rehita Mate Utaetae, the Breast Cancer Foundation National Register. Having our own data for research and service provision will drive improvements in cancer survival, including closing the gaps in outcome for Māori, Pacific and rural breast cancer patients.

Endocrine therapy remains a key component of treatment for hormone receptor-positive disease. Many GPs will notice changes in the recommended duration of treatment with the aim to extend survival, looking to 10- to 15-year outcomes. In 2022, Pharmac funded adjuvant immune therapy for eligible patients.

Metastatic breast cancer is also an area of change in breast cancer treatments, with some improved access for life-extending drugs. Lobbying continues for fully funded access to more medications. Access is currently inequitable, requiring people to self-fund life-extending medications such as KEYTRUDA®.

Breast cancer is a treatable condition for most people with early detection. Conversations we have with our women to participate in breast screening and present early with breast changes save lives.

The way the BSA programme works is changing. A new population register being implemented in 2024 means that women will be invited automatically invited to the programme.

What can you do?

- Actively encourage eligible women to participate in the BSA programme, as regular screening saves lives. Check eligibility and other helpful information here.
- Encourage women to be breast aware, know the signs and symptoms.
- Contact your local lead provider to see how you can help in your region.

> “One in nine New Zealand wāhine will develop breast cancer in their lifetime.

Benefits of Lifestyle Medicine

Dr Laura Pfeifer

GPEP3+ PRIME-trained registrar and triathlete

Addressing the root cause

Lifestyle medicine (LM) emphasises the impact of our lifestyle choices on our overall health and uses evidence-based interventions to prevent, treat and reverse disease. It is not a new concept but rather the foundation that health is built upon. As health care professionals, we recognise that a pivotal shift is needed from solely treating symptoms to addressing the root causes of disease. In the past, the focus of the traditional medical model was on diagnoses and treatment of disease once it had already manifested, whereas LM focuses on prevention.

An LM perspective gives patients active roles in their own health, empowering them to make informed choices that positively affect their overall wellness. Time is taken to utilise behavioural change psychology and motivational interviewing techniques. Management involves integrative therapies, individualised plans and lifestyle modifications, including: nutrition, physical activity, social connection, stress management, avoiding risky substances, and getting adequate sleep. These encompass the pillars of LM.

Interventions

Consider an overweight person with metabolic dysregulation who presents with elevated blood pressure. Instead of traditional prescribing, LM suggests a dietary intervention, such as whole, plant-based and unprocessed foods, introduction of regular cardiovascular exercise starting at their current fitness level, avoiding alcohol, stress reduction techniques, and strategies for improving sleep quality. The outcome is not only a reduction of blood pressure, but a comprehensive transformation in the patient's overall health. Of course, not all of the above things can, or should be, attempted at once. The LM process is a journey of small steps, and it will take as long as the person needs to establish new habits.

As the saying goes, first do no harm. LM interventions should be seen as the first line for addressing mental health problems, improving blood pressure, lowering lipids, glucose regulation, weight management, and sleep issues. I once worked with a 30-year-old woman with intellectual challenges who presented with typical symptoms of type 2 diabetes. Her HbA1c was high 80's, she was unemployed and had stopped playing sport following a knee injury. We had an education session with her family there for support, we then made a plan to gradually add physical activity, tailored grocery shopping lists and

Dr Laura Pfeifer is a GPEP3+ PRIME-trained registrar working rurally in Methven, with a special interest in mental health and sports medicine. She is also a part-time triathlete. She has been a member of the Australasian College of Lifestyle Medicine for the past two years and has completed her Fellowship in Lifestyle Medicine.

simple recipe ideas, worked on establishing social connections and started low-dose Metformin. Over six months she gained meaningful employment, joined a social soccer team, lost 15 kg and reversed her type 2 diabetes. The cost was six consultations. The health expense of a diabetic diagnosed at 40 years of age in New Zealand is over 1 million dollars.

Where to begin?

Time is one of the biggest challenges for Lifestyle Medicine, but we can plant seeds for our patients within a general consultation. A few simple questions that you could try:

1. What do you do to look after your health/to stay well?
2. What would being "healthy" look like in your life?
3. What change could you make tomorrow to improve your health?

Take home message

Lifestyle medicine is not just a buzzword. It underscores the importance of evidence-based practices in improving patient outcomes and quality of life. The bonus is that it engages patients in their health, and it costs far less than the medical care provided by the ambulance at the bottom of the cliff. Being a lifestyle medicine practitioner means embracing a holistic approach, empowering patients, advocating preventative health in our communities and political policies, and assisting transformations in our lives.

What do you currently do, or what could you do differently to bring this type of approach into your patient consultations?

> "The LM process is a journey of small steps, and it will take as long as the person needs to establish new habits.

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Reflections

Dr George Tripe

GP, College member for 48 years

As we celebrate the 50th anniversary of being The Royal New Zealand College of General Practitioners, we're sharing some reflections of a recently retired member who practised as a specialist general practitioner for almost five decades. Dr George Tripe has recently retired from general practice after a long career spanning 48 years.

In this issue, Dr Tripe shares memories from his childhood and his decision to study medicine, as well as sharing his experiences of working on the frontline of primary care and what needs to happen now so we can ensure we have a workforce that is well resourced, well supported and well equipped to improve community health outcomes for the next 50 years and beyond.

Origins and history

My family had a sheep and cattle (pastoral) farm inland from Whanganui. I am one of five children but separated in age somewhat from my siblings. My early education consisted of correspondence lessons supervised by my mother, until I went to boarding school at the age of 10. When I finished school I went back to work on the family farm for a year. My recollections during that year are of digging postholes and dagging old ewes.

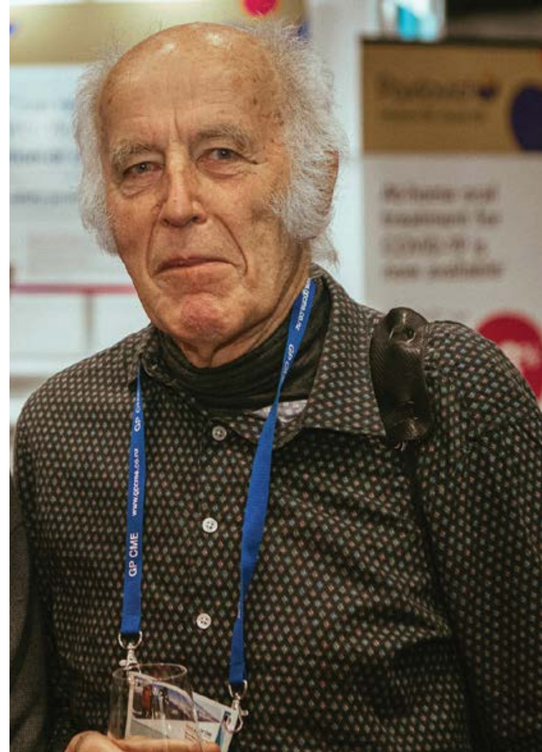
I did an intermediate year at Canterbury and then had to decide whether I went to Massey to learn more about the scientific side of farming or go to medical school. Medical school won out and I attended Otago University and graduated with my medical degree in December 1971.

My house surgeon years were divided between Wellington and Lower Hutt Hospitals. I remember walking out of casualty at the end of my 12-hour shift wondering why so many children from Porirua were travelling into Wellington Hospital in the evenings presenting with relatively minor ailments such as upper respiratory tract infections.

This was because there were inadequate primary care services available in Porirua and some families chose to travel the 30-odd kilometres into Wellington to be seen by a doctor. There were of course problems for those people without their own transport – bus, train and bus again were not just expensive but very time consuming.

Improving health outcomes

With the lack of after-hours care for the Porirua region playing on my mind, I called the Ministry of Health and asked how I could go about establishing a general practice/primary care service in East Porirua. I spoke with Dr John Hiddleston, Director General of Heath at the time, who had been out in East Porirua with the Minister of Health looking at sites for the Government to establish a new health centre.



Dr George Tripe is a GP who recently retired after 48 years as our member.

Photo by *New Zealand Doctor Rata Aotearoa*

This was after the 1972 election and the Government directed Wellington Hospital Board to set up a centre in East Porirua and I, as a house surgeon employed by the Hospital Board, became involved in the planning (design and operations) of the Waitangirua Health Centre. Each doctor at Waitangirua had two adjacent rooms with an interconnecting door allowing for patient privacy and easy access to the nurses to discuss any areas of concern. We also had a treatment room with separate operating facilities, a room for a physiotherapist and another for a social worker, as well as providing a base for the district nurses working in the area.

The importance of wider team collaboration

One of the key factors about the services we provided was having a hospital-employed and salaried nurse seconded to work with each of us in the centre. The nurses who worked with us got to know the patients and were seen by many as an extension of their chosen doctor. Patients seemed comfortable sharing things with the nurses and taking their advice. Nurses and doctors were seen by many as having the same professional status.

I had great confidence in the two nurses that I worked with. Together we would make a diagnosis and then one of us would monitor and follow up with the patient depending on the condition and the confidence of the patient. The key to this working so well was reciprocal trust and appreciation of one another's diagnostic and management skills. The social worker, the nurse and I had weekly meetings to discuss any issues we might have with patient care. We worked as a team, and we worked well together.

Continuity of care versus burnout

After 15 years in Waitangirua I started to feel overwhelmed by patient expectations. I had helped them through some major issues and felt that some of them had expectations of me to do more than was possible. The advent of computer records and the difference in record keeping I was not comfortable with and was a trigger for me to move out of Waitangirua to establish my own practice in nearby Paremata. A number of patients followed, but I was unable to attract other practitioners and became progressively burnt out, especially with the added worry of a falling income as maternity services were taken over by midwives.

In 2000 I decided to cease having my own practice and went locuming in Australia. My earliest experience was in Lightening Ridge, an opal mining town in northern New South Wales. I soon learned, particularly in rural Australia, that if I did not address an issue with a patient there was often nobody else to do it. This led me to think more laterally and find a way of doing things that were sometimes rather outside the square.

For the next 20 years I worked as a locum in predominantly rural Australia and New Zealand, and I learnt to deal with a great range of conditions and health concerns, often with limited resources, which is still an issue we face today. From about 2015 I was back in New Zealand, in South Westland covering five clinics from Harihari to Haast. Each clinic had a nurse who worked in the practice but also covered afterhours emergencies and provided district nurse

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The key to this working so well was reciprocal trust and appreciation of one another's diagnostic and management skills.

services to the community. Some nurses also worked as child health and public health nurses.

The lesson here is that working in a close relationship with an experienced nurse in whom one has trust (which is reciprocated) enabled me to provide insightful and appropriate treatment and management for patients in the community. My experiences as a locum were challenging at times but largely successful. They, however, are not so important when looking at where the health service should be going.

Remuneration and recognition

Remuneration for and recognition of these expanded roles is important. For some, the satisfaction of doing a good job and being appreciated by the patients is enough, but where people are going that extra distance for their community that should be acknowledged.

There are practical issues that also need looking at: short-term locums being paid the same as long-term committed practitioners. There are few clerical assistants to assist the practitioners – they run the accounting system and appointment schedules rather than writing the referrals or notes.

Another area that needs addressing is the differentiation of remuneration and other conditions between nurses and other assistants so that these people not only feel valued but are appropriately rewarded. It is not their qualifications or recognised scopes of practice that matter but their experience and ability to work cooperatively with colleagues.

Where to now?

When I look at the health sector and the services we are providing, it is clear that GPs and other health professionals are not being supported to provide their communities with the health care that they should be getting. There is not the continuity of care and the relationship building between patients and their health practitioners. Adding a nurse practitioner to a primary care team may help, but it depends on the practitioners. Similarly, some secretarial support can allow practitioners to give more time to more patients and help to overcome the doctor shortage.

There is also the issue of increased administrative burden with note taking and inbox management. These tasks should be undertaken by the practitioners who requested the tests and know the patients – they are often done in what is meant to be our "free time" (evenings and weekends) and is often not remunerated. Working like this will only see the levels of burnout in the workforce rise and more people looking to leave the profession earlier than expected.

I am glad that I chose to specialise as a general practitioner, and for the most part, look back on my career fondly. Having the opportunity to have an impact on my patients' health journeys has been rewarding and challenging, and I am grateful for the trust, support and encouragement of the teams I have worked within over this time.

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Adding a nurse practitioner to a primary care team may help but it depends on the practitioners.

Reflections

Dr Glennis Mafi

GP for 46 years, founder of a NZ-style general practice in Tonga

For 17 years **Dr Glennis Mafi** lived in Tonga where she set up a NZ-style general practice and was actively involved with the Tonga Medical Association. After returning to New Zealand in 2001, she continued to oversee the Village Mission Clinic in Tonga, added a retail pharmacy, and worked for the Tongan Health Society in Auckland, until her retirement.

The Village Mission Clinic in Tonga

I moved to the Kingdom of Tonga in 1984 with my Tongan husband and children, planning to set up a primary care clinic, something which was greatly needed. There was no New Zealand–style general practice at the time, no clinic that focused on whole person care, screening, prevention, etc. Some hospital doctors had private clinics that worked as general clinics in the community, but none of them had training in general practice. Some were trained in specialities such as surgery or ENT, but they would maintain they were generalists.

Community medicine was more about being the ambulance at the bottom of the cliff. I wanted to be the fence at the top too. I set up the Village Mission Clinic with practical help from my husband, and it became well-known and well-respected, especially for its fairness in approaching patients, listening to their stories, giving examinations, and giving a simple explanation before a treatment plan. I tried to keep up-to-date via the few medical journals I received (with no computer or internet access), but it wasn't easy with family and other responsibilities.

Then I learnt that the MCNZ would be setting in place requirements for doctors to prove they were keeping up-to-date and maintaining an expected standard of care. What could I do, working mainly in Tonga, but wanting to maintain my New Zealand registration?

Joining the College

The advice for GPs was to join the College. When I graduated from medical school in 1973, I was told to do hospital runs that would be useful for general practice, but there was no strong advice or pathway to join the College, and many GPs just drifted into their careers, picking up experience and 'tricks of the trade' from more experienced GPs along the way, like Dr Ken Blaikie who had been my employer and mentor for several years before we came to Tonga. So, I contacted the College and my new journey began.

I first set about trying to paint a picture of what New Zealand–style primary care was like on main island Tonga. My story included the history of my little Village Mission Clinic, its facilities and services, the staff, the range of patient presentations, and the local hospital and government services, including radiology and laboratory, which were so limited.

I also listed my attempts to keep up to date: my journal reading, and my very faithful attendance at the weekly Tonga Medical Association (TMA) lunch-time meetings, presented in turn by different departments, including Village Mission Clinic, and that sometimes covered business matters. Occasionally there would be a visitor, perhaps a doctor from WHO talking about TB, or

a visiting specialist. Very occasionally there was the excitement of having a drug company rep visit Tonga. It was so infrequent that when they did show up, I was happy to accept the information they brought, the gifts and very occasionally a nice hotel dinner and talk, with little regard to the possible bias. I joined the TMA Committee, and among other things, helped to organise the annual TMA Conference. And when visiting New Zealand, I would do some locums and attend whatever CME meetings I could.

Pasifika in Henderson

The next step in my membership journey was to move to New Zealand to work in a recognised general practice for six months, and during that time have a practice visit. I was privileged to work in Pasifika (forerunner of The Fono) situated in Henderson with Dr Collin Tukuitonga as one of my colleagues. I had to keep a detailed record of a hundred consecutive cases for the College, and host my College visitor Professor John Richards. What a lovely man. We got on so well, he reviewed my Village Mission Clinic report, my 100 cases and sat in with me and my patients for a morning, though he declined my invitation to visit my 'real' place of work in Tonga.

Membership

Not long after that, in 1996, I received my membership of the College, and two or three years later, all of us older doctors, who had been admitted as members through a similar path, were also awarded College Fellowship. So began my years-long relationship with the College, which has been so valuable. This month, not without a twinge of sadness, I resigned from my membership, nearly four years after my retirement.

I wish you well as you mark your 50th year.

The Village Mission Clinic as it was at about the time Glennis Mafi was working on her membership in the College. Although it moved into Nuku'alofa in about 2010, and has been in two different rented facilities since then, these photos show what it was like back in 1996.

> "Community medicine was more about being the ambulance at the bottom of the cliff. I wanted to be the fence at the top too.

Supporting practitioners to support whānau

A presentation during GP23: the Conference for General Practice

A three-year research programme exploring ways to make it easier for primary care professionals to respond to whānau violence has shown that working collaboratively with social service agencies can achieve positive results for victims as well as for health care professionals.

About Atawhai

Based in Tauranga Moana and operating throughout the Bay of Plenty, Atawhai uses te ao Māori values in its work with medical and community organisations and believes they help connect those two sectors to address the significant issues caused by family violence. Its research has shown that the values of tika (honesty), pono (truth), and aroha (empathy) are key to helping whānau and practitioners work together in a safe space to achieve tangible changes while upholding the mana (honour), manaaki (support), safety and compassion for one another.

Atawhai Pou Tikanga (cultural authority) Hori Ahomiro (Tapuika, Tūhourangi ki Tai, Te Arawa, Ngāti Awa, Ngāi Tuhoe, Mataatua) says those values are grounded in te ao Māori ways of being and doing. "Even though the research has been going for three years, it's a journey. We have some successes along the way but also there's still more work to be done. It is about providing support to our GPs and ensuring that our Māori health providers are involved too."

Family violence and ill-health

Tauranga Women's Refuge manager and Atawhai co-investigator Hazel Hape (Ngāti Pūkenga, Ngāiterangi, Ngā Puhi) says the connection between family violence and illhealth is clear, with one in three women and one in two Māori women experiencing physical or sexual family violence in their lifetime. "But there is little support for health care professionals," she says. "Atawhai is about strengthening what is out there."

Examples of ill health caused by family violence include physical injuries, unwanted pregnancy, depression and anxiety, eating and sleeping disorders, poor self-esteem, self harm, and increased rates of long-term illness and addiction.

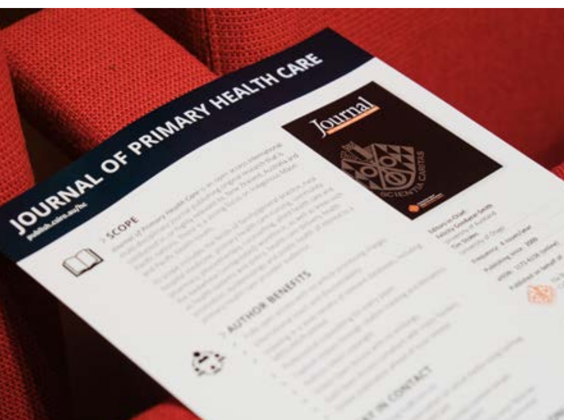
Dr Claire Gear, **Hazel Hape**, and **Dr Claire Isham** presented *Atawhai: Making it safe to talk about family violence in health care* at *GP23: the Conference for General Practice* in July 2023.

A pathway to a better future

Hazel says the Atawhai approach – establishing family violence as a key determinant of ill-health, connecting medical and community service provision, advocating for clinical and cultural supervision and connecting people to information and support – provides a pathway to a better future. “Our GPs hold this privileged space around relationships, so if anything it’s about supporting GPs to have the confidence – like they have with diabetes – to know ‘this is how I can support’.”

Atawhai project lead Dr Claire Gear says GPs appreciate the knowledge and support in an area where they often lack health system guidance. “I think we’re learning, as Tangata Tiriti, how to work with Māori in ways that create space for rangatiratanga. How can we work with kaupapa Māori organisations so they can take what Atawhai has learned and run with it.”

“I definitely think they (GPs) appreciate the time and space to think about these things without having to be on that 15-minute appointment schedule, just having time to debrief and talk about some of the challenges,” she says. “It’s quite different because we’re here to help the professionals, and professionals are often the ones that are the helpers. Atawhai offers a network of support to help professionals feel more confident and capable in doing this sensitive and challenging work.”



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 here.

Trending articles:

1. Addressing rheumatic fever inequities in Aotearoa New Zealand: a scoping review of prevention interventions
2. Asian migrants navigating New Zealand primary care: a qualitative study
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

Remembering Dr Tom Mulholland

10 February 1962 – 8 October 2023

Dr Samantha Murton
GP, President of the College

We were deeply saddened to hear of the passing of Dr Tom Mulholland. Tom was not a member of the College but worked amongst us and touched many of our members' lives. He was a relentless champion of mental health and had a huge impact on rural communities, wrote books, and worked across the Pacific. Never afraid to do things differently, Tom leaves a legacy that will have a lasting impact.

Our sincerest condolences go to his family and friends, and we hope you can celebrate all the great things about Tom in this time of grief.

I would like to remind members that the College provides all members with access to EAP services, and I encourage any who have been impacted by this loss to take up that opportunity.

Messages for Tom's family can be left here.

"He was a relentless champion of mental health and had a huge impact on rural communities.

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

Make your voice heard

Submit your article to the Editorial team:

communications@rnzcgp.org.nz

Do GPs have an obligation to teach?

A presentation during GP23: the Conference for General Practice

Associate Professor Ben Gray presented *Do general practitioners have an obligation to teach?* at *GP23: the Conference for General Practice* in July 2023.

Associate Professor Ben Gray believes specialist general practitioners have an obligation to teach. “A career in general practice is incomplete unless it includes time spent teaching the next generation,” Ben says.

Ben teaches in the Department of Primary Health Care and General Practice at the University of Otago in Wellington; he’s also a retired GP. He wants a paradigm shift in the way teaching is valued and sees this as a means of attracting more medical students to the specialisation.

Hippocratic oath

The idea of teaching, or passing on knowledge, is part of the Hippocratic oath and threads through the bodies that govern all medical practice. The status of teaching hospitals is elevated because of this work. In general practice, teaching does not attract the same prestige.

Nevertheless, the transfer of knowledge is central to the College’s General Practice Education Programme (GPEP). GPEP is delivered by Fellows contracted as medical educators, teachers, evaluators, assessors, and examiners to develop the next generation.

Why teach?

But at a time when the general practice workforce reports feeling under-valued and over-burdened, what is the attraction of teaching?

“It’s certainly easy to find the obstacles,” Ben says. “Being too busy is a constant and on top of that, there’s little financial incentive, and having a student in a practice means making space for them and providing tools.”

Ben says the benefits outweigh the obstacles. “The students you teach will teach you: teaching a student is a chance to re-examine and reflect on what you know, as you see it through their eyes.”

In practical terms, students mean there is more doctor time available within a practice, although Ben warns of seeing students as a service. Their learning must always be the priority.

CQI and Equity modules at Ōtorohanga Medical Center

Ōtorohanga Medical Centre (Ōtomed Ltd) has been serving the local community of the rural King Country area (Ōtorohanga, Waikato) for over 50 years. The current premises were purpose built and have been operating since 2019. The building is a result of a community fundraising, which eventually reached over $3 million, including two incredibly generous donations of $1 million each from two local farming families. The modern and functional workplace has allowed expansion of services to the Ōtorohanga community. The practice's rent goes back to the community via the Ōtorohanga Community Trust and is distributed by sponsorship of things such as school sporting uniforms, re-sealing the local netball courts, and even the purchase of a horse for the local Riding for the Disabled organisation.

The new building is more than just a medical centre. It includes an onsite Pathlab, pharmacy, theatre, x-ray room, ultrasound rooms, and a four-bay casualty. The practice is proud of its artwork carved and painted by local artists, specifically for the space. The artwork captures the significance of community and Ōtorohanga's strong connection to Māori history.

A group photo of the staff in front of the general practice

Ōtorohanga Medical Centre has 30 staff members (both permanent and casual), including GPs, nurses, administration, and MCA teams. Apart from five regular GPs, they also regularly host registrars, junior doctors and medical students. It is both a rural and teaching practice, which takes pride in giving registrars, students and junior doctors a comprehensive experience during their placements.

CQI module

The practice purchased the College's Cornerstone® CQI and Equity modules as these are required for them to be a teaching practice. The community had become isolated by the need to work virtually due to the COVID-19 pandemic and the following lockdowns, and many of their routine services, such as childhood immunisations, cervical screening, etc. had to be deferred during that time. For this reason, their CQI project focused on whakawhanaungatanga: reconnecting with the community, and creating a chance for the community to also reconnect with each other. The goal was to make it family-focussed, fun and interactive.

Te Whatu Ora provided Bowel Screening education and promotion with FIT kits available to take home for eligible visitors, and the Mobile Dental Nurse Service was well attended by kids from 1 to 18 years old. Whānau Ora Healthy Homes set up a stall providing on the spot assessments and applications, and St John Ambulance staff provided a sausage sizzle and showcased their free Health Shuttle. Whāre Awhina promoted their local health and social services ranging from helping with transport to health appointments and counselling to family violence support and budgeting services.

We have built on relationships and whanaungatanga with local organisations and groups within the community such as Kaupapa Māori services Ngāti Maniapoto Marae Pact Trust and Kokiri Trust to help us identify the needs of our population from their perspective. The idea of this is two-fold: to open conversations about potential barriers to access to health care, thereby giving a consistent voice to some of our most high-needs patients; then to collaborate services in order to provide holistic wrap-around care of the whole whānau and wider community.

Equity module

Ōtorohanga Medical is committed to achieving equitable outcomes. The Equity module encouraged the staff to address any unconscious bias and to ensure the practice culture was inclusive and equitable. They have established permanent and dynamic processes, policies and procedures to ensure equity is an ongoing priority, and all team members continually monitor the status of such.

This year they have implemented nurse-led clinics to increase equitable accessibility and affordability of treatment to patients. Training is under way for nurses to become designated registered nurse prescribers in community health (RNPCH) to prescribe treatment for common conditions. Nurse-led ear micro-suction clinics are under way with great success. They purchased

a spirometry machine and have been running regular spirometry clinics this year, with the purpose of engaging their high-needs respiratory patients to ensure they are receiving a high standard of regular monitoring. This flowed into their pre-winter wellness nurse-led clinics, which have proactively targeted their patients with chronic respiratory illness, with the goal of keeping them as well as they could be going into the winter season. They also established drop-in free cervical screening and men's health clinics. They worked collaboratively with Te Whatu Ora to provide walk-in immunisation catch-up clinics for scheduled immunisations across the lifespan.

They continue to utilise quarterly equity meetings between management, directors and equity champions to reassess their strategies collaboratively, based on updated targets, statistics, and patients and staff feedback. Quarterly provider meetings involve leaders from outside agencies coming together to discuss ideas, health care changes, updates and strategies within each sector, in a collaborative effort to stay connected and align services where they can. Monthly staff meetings involve equity components to reinforce their understanding of equity challenges and cultural education whilst empowering all staff to engage with their input, ideas and feedback.

Looking back

The modules created an opportunity to reassess their processes and ensure everything was valid and up to date. They have always had strong connections with other health providers within the community, but the modules were useful in ensuring these connections were reinstated following the pandemic.

"The modules created an opportunity to reassess their processes and ensure everything was valid and up to date.

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